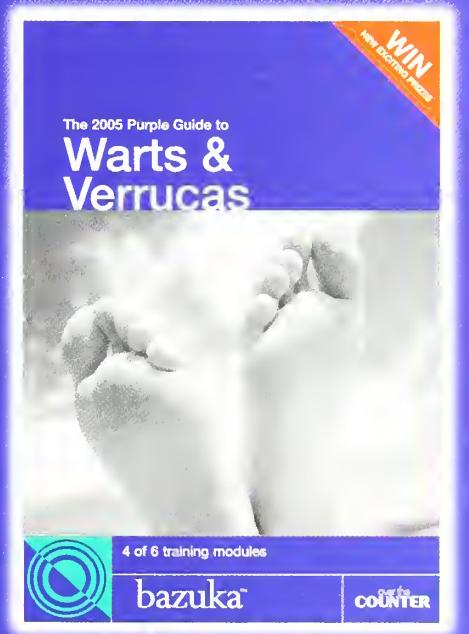


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**DoH clarifies
19 enhanced
services & MUR**

**Troubled Boots
sells OTC group
to bolster BTC**

**NPA restructures
as a Group with
five directorates**

**How to go about
caring for your
customers' pets**

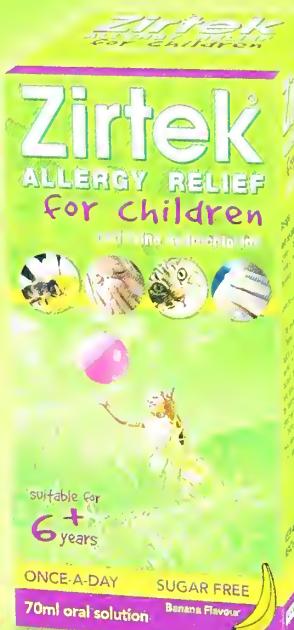




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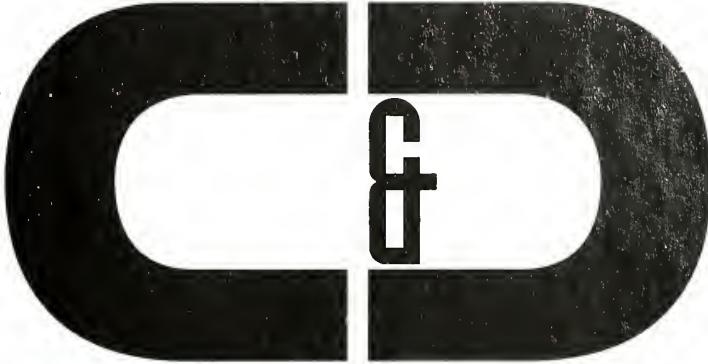
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DoH ends MUR 'wishful thinking' **4**

NPA chairman Ash Soni hopes the Department of Health's new Directions on Advanced and Enhanced Services will put an end to any confusion over the scope of a Medicines Use Review. The NPA believes the situation has led to some 'wishful thinking' on the part of some PCTs

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United Business Media



DoH ends MUR 'wishful thinking'

Confusion about the scope of a medicines use review has led to 'wishful thinking' by some PCTs, says the National Pharmaceutical Association. It is worried that some PCTs have seen MURs as a more cost effective solution to commissioning medication reviews as an enhanced service.

However, the Department of Health's latest guidance for advanced and enhanced services will provide some overdue clarity, putting an end to such beliefs, hopes NPA chairman Ash Soni.

The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2005, lists 19 enhanced services that PCTs may arrange with pharmacists on its pharmaceutical list.

The 19 services are listed as directions (see panel), which have a higher status than guidance, to the new pharmaceutical services regulations for England.

The directions also list the purpose of MURs and prescription interventions to be conducted as advanced services, which is to improve a patient's knowledge and use of drugs by resolving poor and ineffective use of drugs and identifying factors affecting compliance.

NPA chairman Ash Soni said that some PCTs had mistaken MUR for a full medication review. "There is a significant difference," he said. "A usage review is only designed to establish whether patients understand what their medicines are for, are taking them correctly, if they are suffering any perceived side effects and are using optimised doses. The only medication changes that would be suggested would be those that optimised doses or changed the formulation/form if the patient was not complying because of difficulties taking medicines." **AC**



The service directions

These include:

- Monitoring and screening for patients taking anticoagulants or those at risk of developing a specific disease or condition.
- Advice and support to patients and staff in care homes, to vulnerable patients or those with special needs, those who wish to give up smoking, those with a specified condition, or those with whom there is a language access issue, to prescribers and to schools staff and children.
- Supply of gluten-free foods, home delivery, treatments for minor ailments, needle and syringe exchange, on-demand specialist drugs, supplies out of hours or under patient group direction, under supervision or a supplementary prescribers' clinical management plan.
- Medication review – assessing a drug's appropriateness and effectiveness on the basis of information and test results in the patient's care record.

CCA pushes for pharmacy in OOH care

Local pharmaceutical committees should contact primary care organisations to identify pharmacy's role in out-of-hours care, the Company Chemists' Association has said.

Furthermore, alongside PSNC and the NPA, the CCA will work to ensure PCOs are aware of the opportunities to integrate pharmacy into OOH networks, said the organisation at its April board meeting.

This is particularly important because contractors in England and Wales have reported a short-term PCO funding deficit for pharmacy rotas, said the CCA.

SPGC surveys contractors over loss of GP OOHs

Scotland's negotiating body for pharmacy contractors is investigating how the decision of GPs to opt out of providing out-of-hours services is impacting on pharmacists.

The Scottish Pharmaceutical General Council is asking pharmacists how they are meeting any increased demand for pharmacy services and says it plans to present this evidence to the Scottish Executive to seek funding for the new workload.

Alex MacKinnon, SPGC professional services development head, said there was "every indication" that the withdrawal of GPs from the provision of out-of-hours services over weekends, evenings and bank holidays, had

"impacted considerably" on NHS24 and community pharmacy.

Pharmacies were experiencing "unprecedented increases" in workload during Saturdays and on bank holiday Mondays, he said. NHS24 was also experiencing a steady increase in the number of calls with a "noticeable spike up" on Saturdays resulting in more referrals to community pharmacy.

"This situation has produced a significantly increased workload for community pharmacists and their staff."

He had been told that meeting the new demands of unscheduled care had in many instances necessitated rescheduling of staff hours and increased staff hours.

SOS sweeps to victory in RPSGB election

All 13 Save Our Society candidates have been elected to the Royal Pharmaceutical Society's Council, the Society announced this week.

They are, in order of the votes, Hemant Patel, Martin Astbury, Graham Phillips, Stephen Wells, Gerald Alexander, John Gentle, John Jolley, Sultan Dajani, Davan Eustace, Andrew McCoig, Shiv Bagga, Douglas Simpson and Bharat Nathwani. Dorothy Drury was the only non-SOS candidate elected to the unreserved seats.

Jonathan Buisson was elected to represent the national seat for England, the Isle of Man and the Channel Islands; David Thomson for the seat for Scotland; and Colin Ranshaw for Wales. Corinne Hunt and Lesley Morgan were elected as pharmacy technicians.

Of the 45,427 ballot papers distributed, 21.7 per cent were returned, with 0.1 per cent of these invalid.

The SOS candidates won 59 per cent of the votes for the 14 unreserved seats and now have a clear majority of the pharmacists on the Society's reformed Council.

An RPSGB spokeswoman said that the appointment of the lay members and the election of an academic pharmacist were still in progress.

SPGC is asking contractors to quantify the workload over the Easter Bank Holiday weekend, and for next month's bank holiday weekend. Contractors are asked to state how many emergency supplies were completed, if any extra staffing was needed, and the number of referrals to NHS 24.

SPGC chairman Frank Owens said he was aware of an "increasing body of anecdotal evidence suggesting an urgent need to address the issue".

"Community pharmacy is ideally situated to play a major role in filling the gap left behind by the new GMS arrangements. However, we cannot be expected to continue to do so unsupported," he said.



927 fail to pay their fees

The Society is removing 927 members from the Register for failing to pay retention fees, Council members heard last week.

Affecting 2 per cent of pharmacists, the figure is much higher than previous years when around 350 members were struck off for non-payment of fees. But, the figure is "half that anticipated, so well within levels of acceptability", said RPSGB finance and resources director Bernard Kelly.

Look at fees, says Glover

The Royal Pharmaceutical Society needs to revise its retention fees structure, Council member Christine Glover said last week.

Speaking at her last full Council meeting, Mrs Glover said: "Disenfranchising pharmacists who have given a lifetime of service to pharmacy cannot be the right way for the profession to behave." She also called on the Society to consider how it applies CPD, saying not allowing pharmacists who were not on the practising register to give medical advice was "plainly ridiculous".

A full version of Mrs Glover's speech appears on p18.

Boots The Chemists will reap spoils of BHI sale

Boots The Chemists is emerging as a likely winner from the proposed sale of Boots Healthcare International and the £250 million store sale and leaseback programme.

Despite issuing its third profits warning inside 19 months, chief executive Richard Baker revealed that the sale of the BHI OTC medicine manufacturing division plus the 300 small store leaseback and sale programme could net the company as much as £1.5bn, as much as half of which could be used to pay down short term borrowings and speed up the ongoing modernisation programme at the Boots The Chemists chain.

Despite a tough fourth quarter, in which like-for-like sales at the pharmacy division fell by just under 1 per cent, adding to the prospect of depressed operating profits of around £470m for this

year, Mr Baker described the pharmacy chain as a "rejuvenated, growing business, competing strongly in the core toiletries area and holding market shares". Own-brand also offered the opportunity to drive growth and margins, he said.

Explaining his reasons for selling a business once described as 'core', Mr Baker said that BHI, which delivered pre-tax profits up 14.9 per cent to £80.9m last year, had a better future outside the group, despite the fact that the global OTC market was consolidating.

"BHI's continued growth within Boots would have taken lots of time, effort and money, and probably acquisitions. There is no quick and easy answer; it was felt that at this stage the time and the money would be better spent on Boots The

Chemists," added a spokesman.

City analysts, however, have been more mixed in their response to the news of the proposed BHI sell-off. JP Morgan, for one, described the move as "selling the crown jewels".

Barclays stockbrokers, though, felt that the decision to return the other half of the BHI sale proceeds to shareholders provided "an element of support for the share price", which could shore up the company's position in light of the rumoured interest of private equity firms in acquiring the group.

Analysts have named GSK, Pfizer, Reckitt Benckiser, McNeil and Boehringer Ingelheim as potential bidders for BHI, although these were unavailable for comment as *C&D* went to press.

Control of entry guide for PCTs

The DoI has published guidance to help PCTs assess applications to provide NHS pharmaceutical services.

Relating to *The NHS (Pharmaceutical Services) Regulations 2005*, the guidance applies to "chemists", a term that includes pharmacies and appliance contractors (*C&D*, March 19, p4).

In addition to incorporating reforms to the control of entry regulations, the document outlines how the application and decision-making process has been streamlined and gives information on the application appeals process.

Newsdesk
01732 377688



NPA Group is formed from the restructuring at St Albans

The National Pharmaceutical Association is to reorganise its structure to incorporate its financial and insurance services under a new NPA Group.

The strategic plan will give the group a "sound organisational structure" and will formalise the informal cross-working that already exists between the NPA with its Chemists' Defence Association, Pharmacy Mutual Insurance and the Pharmaceutical & General Provident Society. These all operate out of Mallinson House in St Albans.

The changes will set up five directorates in three areas: the

NPA (with the core practice and commercial functions), insurance, and shared functions (group services and marketing). The NPA is recruiting three new directors who will join existing directors Colette McCready and Richard Maw in the senior management team. John D'Arcy will remain chief executive.

The NPA, the CDA, PG and PMI will have their own boards, but an NPA Group steering committee will oversee the boards. The NPA is also recruiting for a compliance officer to ensure the group meets requirements such as those set out in the *Companies Act*,

Data Protection Act and other legislation. In addition, Mr D'Arcy says there will be some expansion of the teams as well as some redeployment of staff at Mallinson House.

Mr D'Arcy said that the changes have been brought about to reflect the synergies of the various parts, but will also allow the group to grow. "For the members there's not going to be much of a dramatic impact - it just creates a formal structure for what we have been doing informally."

However, he hopes that there will be real results in terms of

improved performance and increased revenue by the end of the year. Improved business should enable the NPA Group, which will remain a not for profit organisation, to further subsidise membership fees. "The important thing is that the culture of mutuality pervades."

Influencing factors include all the regulatory requirements for the financial services industry, the fact that the new pharmacy contract has been brought in, and because of the NPA's successful year in 2004. The NPA is aiming to have the new structure in place by July. **CRG**

PHARMACY

£5,000 research grant for joint project

A £5,000 grant is available to fund joint research between community and hospital pharmacy.

The Joint Award, now in its seventh year, is an initiative of the Guild of Healthcare Pharmacists, the National Pharmaceutical Association and Merck, Sharp and Dohme. It is open to pharmacists from all branches of the profession but must reflect a joint project between community/primary care and hospital pharmacy.

Last year's winners were Steve Gray, a community pharmacist from Berwick, and Mike Urwin and Sheila Woolfrey, Wansbeck General Hospital, Northumbria. Their project aims to find out if copying discharge letters from the care of the elderly consultant to practice pharmacists improves the



£5,000 research grant for joint project between community and hospital pharmacy. The grant is available to fund joint research between the Guild of Healthcare Pharmacists, the National Pharmaceutical Association and Merck, Sharp and Dohme. The grant is open to pharmacists from all branches of the profession but must reflect a joint project between community/primary care and hospital pharmacy.

implementation of treatment plans when patients are discharged from hospital.

Application forms and resource packs from www.ghp.org.uk or www.upa.co.uk **AdM**

Multiples now dominate pharmacy scene

The number of pharmacies in chains of more than five has increased nearly 60 per cent over the past nine years, revised DoH statistics reveal.

Correcting the *General Pharmaceutical Services in England and Wales 1994-95 to 2003-04* published in January, the figures show 53 per cent of pharmacies now operate in a chain of more than five, up from 33.6 per cent.

The number of pharmacies dispensing more than 10,000 items per month has soared from 177 to 661 (a 273 per cent rise) while the number of pharmacies dispensing fewer than 2,000 items a month has more than halved from 1,866 to 743.

The average number of prescription items dispensed in 2003-04 was 5,141 per month.

During 2003-2004, pharmacies

in England and Wales received 660.9 million dispensing fees, an increase of 5.4 per cent over 2002-03 while the average NIC per fee in England and Wales increased 7.4 per cent to £11.16 over the same period.

The figures also reveal that 10,462 pharmacies were in contract with PCTs/LHBs in England and Wales, only 24 fewer than in 1994-95. **AC**

EDUCATION

NPA adds Training Seal to new courses

The NPA has awarded its 'Training Seal' of approval to two new courses.

The first, PharmaNord's Certificate in Nutritional Supplements, aims to give a basic understanding of the principles of nutritional supplementation and its role in maintaining normal body function.

The second is for Health Diagnostics' Coronary Heart Checks training course, which covers all aspects of a pharmacy-based heart check including operational procedures, and the measurement and evaluation of blood pressure, cholesterol and diabetes.

AC

Question time

This week's question:

What proportion of community pharmacies do you think will eventually be owned by a multiple?

- 60 per cent
- 70 per cent
- 80 per cent
- 90 per cent or more

You have until noon on April 19 to vote at www.dotpharmacy.com. We will publish the results in C&D on April 23.

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Zoton switch dropped due to licence delay

Wyeth Consumer Healthcare has dropped plans to switch Zoton (lansoprazole) capsules from Prescription Only to Pharmacy medicines status.

The company had intended to launch an over the counter version of the proton pump inhibitor in September last year, following a switch application made in March. The aim was to launch Zoton OTC for the treatment of moderate to severe heartburn and indigestion in adults, based on a dose of 15mg once daily. The company also wanted to claim a fast therapeutic onset.

However, protracted discussions between the company and the Medicines and Healthcare products Regulatory Agency, particularly relating to the speed of onset claims and the MHRA's preferred starting dose of 30mg, pushed back the launch date by around 16 months, to December 2005 at the earliest. This is the same month in which the product loses its patent.

The company was finally forced to abandon its switch plans when the MHRA indicated that it would not grant the OTC version of Zoton the full licence

terms as requested by Wyeth.

Managing director John Smith commented: "While we have been advised that we were still likely to achieve a licence with some advantages over the other OTC PPIs, we would not have been able to fully communicate the superiority of Zoton to customers."

"Unanticipated lengthy delays in obtaining a licence, combined with an imminent patent expiry have meant that the time is not now right for Wyeth to invest the significant sums required for such a major initiative."

AC

PPG2

CHRE cases may cost £400k

A court case brought by the Council for Healthcare Regulatory Excellence could cost the Society up to £400,000, said RPSGB fitness to practise and legal affairs head Mandie Lavin.

But if the Society does not contest a CHRE referral to the High Court, CHRE should not seek to claim its costs, Ms Lavin told last week's Council meeting. In such cases of public interest, the regulator should not be penalised, she said, during a discussion on the RPSGB's response to CHRE's consultation on recovering costs.



Regulation must not curb innovation, says RPSGB

Professional regulation should not stifle innovation, said RPSGB Council members last week.

When considering the Society's response to the Shipman Inquiry's fifth report on the regulation of doctors (C&D, December 18/25, p5), Linda Stone expressed concern that "straitjacket" measures would be implemented. This could constrain pharmacists' good work and inhibit the development of professional roles without achieving greater patient safety, she said.

"Straitjackets don't allow for innovation," she argued. She added that many aspects of the new contract and the DoHs

pharmacy strategy would not have been possible if some of the recommendations in the Shipman report had been in place at the time. RPSGB Shipman working group chairman Elizabeth Filkin agreed, but said: "Getting the balance right is difficult."

The Society's response will endorse the patient-centred and public protection approach of the fifth Shipman report. But despite supporting the recommendations to strengthen the GMC's regulatory machinery, the RPSGB will highlight areas where similar applications to pharmacy could be problematic.

Other issues Council members felt should be included in the

Society's response include:

- the need to focus on secondary, as well as primary care
- the potential for abuse of a telephone helpline that gives patients advice on how to complain about healthcare providers
- awareness that all professional misconduct cases be equally dealt with, whether the Council for Healthcare Regulatory Excellence is involved or not.

Pending some alterations, Council agreed to submit the working party's document as its preliminary response to the Shipman report. Further information would be forwarded to the Shipman Inquiry at a later date, Council decided.

AF

Essential Information
Product Name: Zocor Heart-Pro®
10mg tablets. Presentation: Peach-coloured, oval-shaped tablets containing simvastatin 10mg.

Indications: To reduce the risk of a first major coronary event (non-fatal myocardial infarction and coronary heart disease (CHD) deaths) in individuals who are likely to be at moderate risk (approximately 10-15% 10 year risk of a first major event) of CHD. **Dosage & Administration:** Take one 10mg tablet daily at night. Not recommended for paediatric use. **Contraindications:**

Hypersensitivity to simvastatin or any of the excipients; previous history of muscular toxicity with a statin or fibrate; individuals already taking prescription cholesterol lowering drugs; concomitant administration of potent CYP3A4 inhibitors (e.g. itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone); active liver disease or unexplained persistent elevations of serum transaminases; pregnancy and breast-feeding; women of childbearing potential. **Precautions:** Zocor Heart-Pro® is not intended for individuals who are known to have: existing coronary heart disease, diabetes, history of stroke or peripheral vascular disease, familial hypercholesterolaemia. Individuals with hypertension should consult their doctor before undertaking treatment. Individuals with a fasting LDL-cholesterol level of 5.5 mmol/l or greater should consult their doctor. All individuals must be advised of the risk of myopathy and told to stop taking Zocor Heart-Pro® if they experience unexplained generalised muscle pain, tenderness or weakness. People aged >70 years or with hypothyroidism, renal impairment, personal or family history of hereditary muscle disorders should not take Zocor Heart-Pro® except on medical advice. Product should be used with caution and under medical supervision in people who consume substantial quantities of alcohol and/or have a history of liver disease. If treatment with itraconazole, ketoconazole, erythromycin, telithromycin or clarithromycin is unavoidable, therapy with Zocor Heart-Pro® should be suspended during the course of treatment. Concomitant use with other less potent inhibitors of CYP3A4, e.g. ciclosporin. Individuals with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Side Effects:** Most commonly reported side effects were: abdominal pain, constipation, flatulence, asthenia, headache. The following side effects have also been reported: anaemia, paraesthesia, dizziness, peripheral neuropathy, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis, hepatitis/jaundice, rash, pruritus, alopecia, myopathy, rhabdomyolysis, muscle cramps, myalgia. Apparent hypersensitivity syndrome has been reported rarely. Increases in serum transaminases, alkaline phosphatase and serum CK levels. **Legal Category:** P. **PL Number:** PL 13249/0089. **PL Holder:** McNeil Limited, Saunderton, High Wycombe, Buckinghamshire, HP14 4HJ. **Packaging Quantities:** 28 tablets. **Price:** £12.99 (RRP). **Date of Preparation:** December 2004.



This 45 year old doesn't need a cholesterol test to tell him he needs Zocor Heart-Pro®.

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Simvastatin

Phoenix takes a Quantum leap into Specials

Phoenix has invested a six-figure sum in specials manufacturer Quantum Specials.

Quantum, set up in Wallsend, Tyne & Wear in January by four former managers of Eldon Laboratories following its sale to Martindale Pharmaceuticals (C&D January 1/8, p8), will provide all the specials requirements for Rowlands' pharmacy. It will also offer priority service to all Phoenix customers.

Phoenix CEO David Cole said: "We are delighted to be able to kick-start this new business and Quantum also has a very competent management team in place, which has the motivation and knowledge to provide our mutual customers with the services they need."

Phoenix group finance director Kevin Hudson has joined Quantum's board. Quantum currently has 10 staff, which is expected to increase to 14 with the addition of the Phoenix business, rising to 20 by the summer.

The company is building its resources to enable it to satisfy more than 200 manufactured



orders a day. It operates from clean room facilities and has been granted all the necessary licences and registrations.

Quantum production director Andrew Patterson said the company will supply specials to 488 Rowlands pharmacies from May 1 and will have the

opportunity to gain some of the Numark business from Phoenix in the future.

Quantum aims to supply a range of specials to retail and hospital pharmacies throughout the UK. Mr Patterson says it could be supplying 2,000-2,500 pharmacies by 2006.

JE

JE

INDUSTRY

US drives Boehringer growth

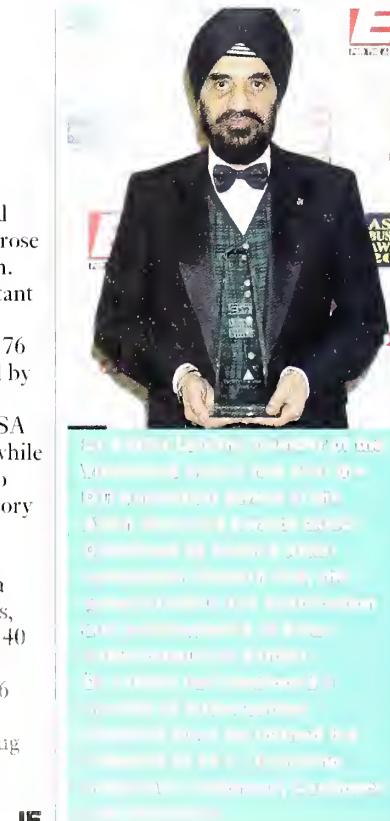
Boehringer Ingelheim reported strong growth in 2004 as sales rose by 10.5 per cent to €8.2 billion.

The company's most important business area, prescription medicines, which accounts for 76 per cent of net sales, improved by 12 per cent to €6.2bn.

Prescription drugs in the USA grew by 18 per cent last year, while business in Germany started to stagnate as a result of compulsory national health insurance payments of €55 million.

The strongest growth was in the biopharmaceutical business, with sales of almost €400m, a 40 per cent increase. This was followed by animal health (up 6 per cent to €335m).

Boehringer's best-selling drug was Alna/Flomax for the treatment of benign prostatic hyperplasia.



JE

INDUSTRY

Pfizer plans three years of cuts

Pfizer will make cost cuts of \$4 billion (£2.1 billion) over three years as it faces a drop in profits as patents on some of its key medicines expire.

The company has also seen a fall in sales of its arthritis painkillers Celebrex and Bextra, both Cox-2 inhibitors, owing to scares over their side effects.

After the restructuring costs and the loss of sales, profits could fall by 25 per cent

to \$8.6bn, the company said.

The cost savings will come from the streamlining of procurement, administration and manufacturing, as well as a reorganisation of its sales force and greater efficiency in research.

Pfizer's chairman and CEO Hank McKinnell said the company had been preparing for this period for "more than a decade", and that Pfizer's profits would recover next year and accelerate in 2007.

JE

PHOTOGRAPHY

Digital minilab for novices

AgfaPhoto's latest digital minilab, the d-lab.ls starter, is aimed at newcomers to the photographic print business.

It features one paper magazine with a capacity of 550 4x6in prints an hour.

The sorter has a capacity for

three orders and can handle a maximum size of 8x12in. Automatic red eye correction is an optional feature.

The d-lab.ls starter can also produce photo CDs and passport photos. It will be available next month.

JE

INDUSTRY

Hollister UK back in business after warehouse fire

Following a fire that destroyed Hollister UK's central warehouse and business services support unit at Ashby de la Zouch on April 4, the company implemented its business interruption plan and has maintained supplies to its distributors.

Sixty fire fighters and 13 appliances were needed to put out the fire. None of the 63 Hollister employees or fire fighters was injured.

The relevant authorities are currently investigating the cause of the fire.

Brett North, Hollister UK's corporate communications manager, said a number of staff have been redeployed to Hollister facilities in the UK, while 40 have temporarily been transferred to the Munich facility which has a dedicated UK pack and despatch operation. Other Hollister businesses worldwide are also assisting the UK with extra stock and logistics support.

"It is anticipated that disruption to customer orders will be minimal," said Mr North. "Our standard delivery promise of two days is back in place."

JE



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Piriton Allergy Tablets and Piriton Syrup Product Information. **Presentations:** Tablets containing 4 mg chlorphenamine maleate. Syrup containing 4 mg chlorphenamine maleate in 10 ml. **Uses:** Symptomatic relief of chickenpox itch and allergic conditions including hayfever. **Dosage and administration:** Tablets: Adults: 1 tablet every 4-6 hours. Children aged 6-12: 1½ tablet every 4-6 hours. Syrup: Adults: 10 ml every 4-6 hours. Children aged 6-12: 5 ml

every 4-6 hours. Children aged 2-6: 2.5 ml every 4-6 hours. Children aged 1-2: 2.5 ml, twice daily. **Contraindications:** Hypersensitivity. Concurrent or recent treatment with MAOIs. **Precautions:** May increase effects of alcohol. May affect ability to drive and use machinery. Use with caution in prostate, respiratory, liver, cardiovascular and thyroid disease, epilepsy, glaucoma and other eye conditions. Syrup contains sugar, use with caution in diabetes. Maintain good dental hygiene. **Side effects:** Sedation. Less commonly gastrointestinal disturbances, blurred vision, headaches, urinary retention, dry mouth, muscular incoordination, jaundice, cardiovascular

disturbances, chest tightness, dizziness, blood dyscrasias, allergic reactions, tinnitus. Children and the elderly are more prone to the neurological anticholinergic effects and rarely may become confused or excitable. **Pregnancy and lactation:** Consult doctor before use. **Legal category:** P. **Product licence numbers:** Tablets: PL 00036/0091. Syrup: PL 00036/0088. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** Tablets 30s £3.15, Syrup 150 ml £3.99. **Date of last revision:** October 2004. Piriton is a registered trade mark of the GlaxoSmithKline group of companies.



GlaxoSmithKline
Consumer Healthcare

Driving incidents lead to striking off

A pharmacist jailed for 28 days after driving his car on the wrong side of the road and colliding with an oncoming vehicle and for stealing medicines has been ordered to be struck off.

The RPSGB Statutory Committee heard it was the second time Philip Terry of Herne Bay, Kent, had driven while unfit. He had previously been fined £300 in June 2002 at Medway Magistrates Court for the offence.

Committee chairman Lord Fraser said: "As noted by the court, it was so serious only a custodial sentence was appropriate. He was in a position of trust, it was the second occasion, he was a danger to the public and injuries were caused to the person he collided with."

Lord Fraser said it was difficult to assess any dependence Mr Terry may have on drugs but added there had been a "high concentration" at the time of the second offence.

Goff Hudson for the Society said that at around 7pm on May 26, 2004, motorist John Ward was rounding a bend when Mr Terry's car came "towards him on the wrong side of the road. When he thought it would hit him, the other driver steered left onto the nearside kerb but was unable to avoid him completely".

Mr Terry carried on driving. The other man thought he was going to stop and when he turned round couldn't see him. He went to look for him. Some 150 yards up the road he saw the car parked.

He saw Mr Terry holding the car as he walked. Two police officers saw him kneeling down by the car; he was swaying.

Mr Terry, who was pharmacy manager at the Newington Pharmacy, Ramsgate, at the time, claimed he had "lost control" of his car, veering across hitting the other vehicle. Mr Ward suffered "whiplash" injuries.

In September 2004 at Thanet Magistrates Court he admitted driving while unfit through drugs, and stealing 92 dihydrocodeine, 15 codine phosphate and one diazepam tablet.

He was given 28 days in prison concurrent on each, disqualified from driving for three years and ordered to pay £42 costs.

Mr Terry has three months in which to appeal.

UKL

Catalogue of problems 'went from bad to worse'

Bournemouth pharmacist Brian Partridge has been ordered to be struck off after a disciplinary hearing heard that an inspection of the premises he ran uncovered a catalogue of problems.

Problems included mixed brands of loose tablets stored in one stock container and dispensing errors to numerous patients. One patient was said to have been given a mixture of unidentified tablets in a number of medical wallets, none of which bore a dispensing label. It was also alleged that while trying to rectify a dispensing error to a 14-year-old girl, Mr Partridge visited her home and made an "inappropriate contact" with her mother "by patting her on the side of the buttock".

The RPSGB Statutory Committee made no finding on the patting allegation but struck him off on the basis of the other allegations.

Committee chairman Lord Fraser said: "Mr Partridge was

repeatedly warned by the Society and a local adviser and matters went from bad to worse." He said the evidence before the Committee "painted a disturbing and bleak picture".

David Bradley, counsel for the Society, said many problems had been revealed by a Society inspector and that these included breaches of the *Misuse of Drugs (Pharmacy Safe Custody) Regulations 1973*.

He said that on January 12, 2004, the inspector, Barry Cohen, found CDs in an open bin in the dispensary, date-expired medicine, and medication with "no visible batch and expiry details". This included patient-returned medicines.

Mixed brands of loose tablets were said to have been stored in one stock container, liquid medicines had no opening dates and further investigations were said to have revealed repeated dispensing errors for six patients.

Mr Cohen was said to have been told by Mr Partridge that one patient's wife regularly collected her husband's weekly supply of methadone without written authorisation and that he had dispensed sugar-free methadone when it had not been prescribed.

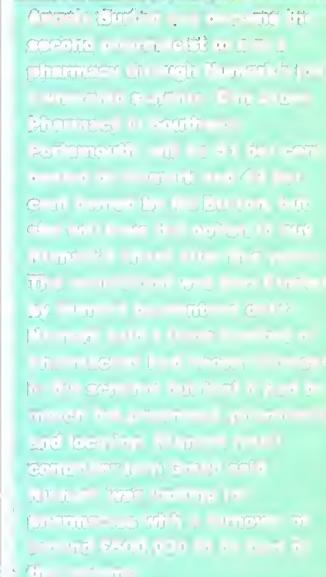
Mr Partridge admitted the allegations against him apart from having made inappropriate contact with the young girl's mother. Mr Partridge said he had taken over the pharmacy in 1994, with "problems" starting in 1997-98. He said there had been various visits from inspectors and things had gone "downhill".

He said: "I worked 9 to 6pm, five and a half days a week, delivered prescription items and took work home usually."

His counsel, David Aaronberg, said: "It is a sad case and luckily no one has been hurt after such a series of errors."

Mr Partridge has three months in which to appeal.

UKL



Society issues guidance on 'whistleblowing'

The Royal Pharmaceutical Society is publishing guidance on how pharmacists and technicians can raise concerns about health professionals' fitness to practise.

Raising Concerns - Guidance for Pharmacists and Registered Pharmacy Technicians outlines the steps needed to report poor or illegal practice to employers, regulators and other authorities. The RPSGB was alerted to the uncertainty surrounding "whistleblowing" last year, when it commissioned a report on the locum workforce.

At last week's Council meeting, Council member Clive Jackson said the document appeared to apply to those working in the NHS only. Pharmacists working in the private sector still had a professional obligation to report poor practice, he said. Council agreed the paper would continue to evolve, but would appear on the Society's website as soon as possible.

• Pharmacists and technicians will be obliged to co-operate with fitness to practise investigations under amendments being made to

the *Code of Ethics*. In addition, the *Code of Ethics* will include a requirement that pharmacists must abide with the conditions of any undertaking given to the Statutory Committee following an inquiry, Council agreed last week.

• The Royal Pharmaceutical Society's reciprocal registration agreement with Australia and New Zealand will end next year.

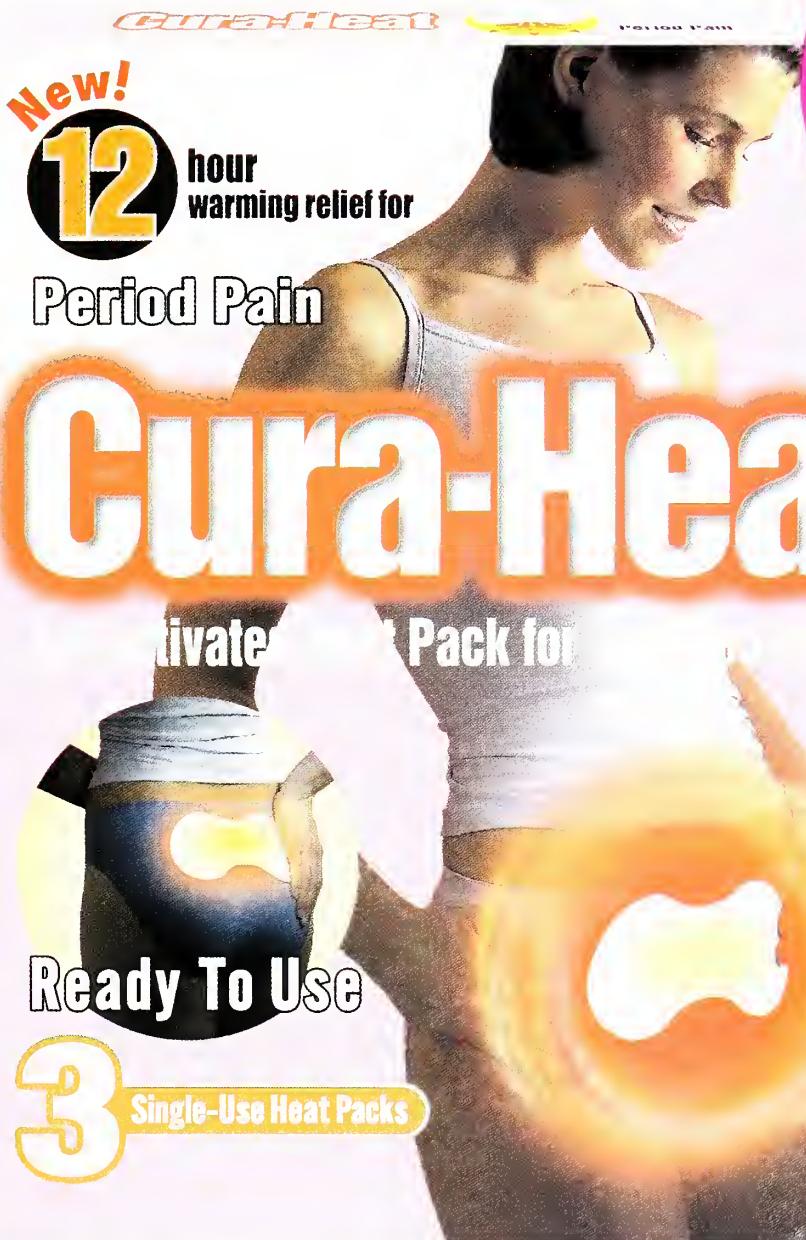
After June 30, all applications from overseas pharmacists, other than from Northern Ireland or European economic area nationals, will be considered by the RPSGB's adjudicating committee. The decision will promote fairness for pharmacists qualifying outside the UK, Council members were told.

A small increase in the number of applications is anticipated before the deadline, Society secretary and registrar Ann Lewis told Council. She added that Australia and New Zealand were still considering how and when their reciprocal arrangements for GB-registered pharmacists would end.

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Our question to pharmacists this week was:

Do you agree with MPs that stricter controls are needed in promoting new medicines to health professionals?

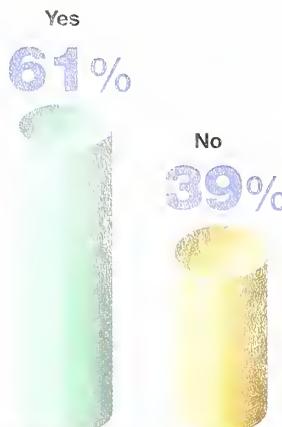
"There's nothing wrong with the way it's promoted at the moment... as long as we're given all the information it's up to the individual prescriber"

**Jackie Campbell,
Derby**

"I think I probably do... I'm not sure how else it can be done but it does need to be looked at"

**Michael McWhirter,
Cornwall**

Our online poll at www.dotpharmacy.com said...



Comment from the Editor

The election results are in and the 'people's party' has increased its number of seats. Not at Westminster, but across the river at Lambeth where the Royal Pharmaceutical Society's new Council will comprise a hefty proportion of elected pharmacists who espouse the SOS point of view.

When SOS came on the scene its intention was to challenge the way that Lambeth was apparently threatening to change the whole nature of the Society, and profession, which had operated successfully for over 160 years. Now that the SOS campaign's initial aim of having a new Charter approved by the membership has been met, where will the SOS campaign turn next?

The SOS manifesto – as pledged by the SOS cohort in the election *Who's who* booklet – appears to address continuing professional development, fees, and membership categories. How ironic that a pharmacist retiring from the current Council who was challenged by SOS campaigners in the high

court should support two of these aims in her valedictory address (see p18).

At Westminster, the effects of a large majority are showing signs of malaise. The Government started with a mandate for reform, but over the years the electorate has seen the negative effects of unchecked power.

While the writing is not yet on the pharmacy wall, pharmacists will have to rely on an increased lay representation for the checks and balances that make for good governance. For a profession which has not had a party political approach, this new system will take some time to bed down.

A word of advice, then. The SOS group should be magnanimous in victory and remember what their appellation stands for: Save Our Society.

Where will the SOS campaign turn next?

Their views

E-mail your views to [chemdrug @ cmpinformation.com](mailto:chemdrug@cmpinformation.com)

ABPI president Vincent Lawton on the dearth of money for R&D

Invest where it's best

This year saw the renegotiation of the Pharmaceutical Prices Review Scheme. The latest, and in our view, unnecessarily imposed price cut comes on top of an 18 per cent erosion of prices in real terms over the past 10 years.

The Government needs to be acutely aware that the commoditisation of medicines is not in the patient's interest.

Commoditisation of vaccines is a salutary example. Twenty years ago, there were 25 companies actively engaged in vaccines research. As a result of global procurement of vaccines, the driving down of prices, and a consequent removal of incentives, there are now just a handful of

companies involved in vaccines research. This includes critical research into an AIDS vaccine.

While nearly a quarter of the world's best-selling medicines are discovered in the UK, NHS patients remain near the bottom of the European league when it comes to benefiting from them.

The French invented democracy, they say – but only for export. The British doctor and patient must be aware of a similar fate for our own scientific inventions. I do not think this is where the new NHS wants to be.

This is a hugely successful industry. It contributes one quarter of all UK R&D, around £10 million each day and the UK

is the world's biggest exporter of medicines with a trade surplus of £3.4 billion in 2004.

Yet we cannot be complacent. This year's ABPI Annual Review highlights some falls in R&D, and capital investment. There is little doubt that competitive pressures from Eastern Europe, Singapore, India and China are being felt.

This Government knows how important a successful and competitive pharmaceutical industry is to Britain's future economic success. But the plain fact is that our industry is global. As such, we invest where it is best for us to do business.

An extract from Mr Lawton's address at the ABPI annual dinner.

Reader REPLY

Category M worries

Am I alone in seeing a bleak financial future for independent pharmacy based on the new *Drug Tariff*? Out of a possible 42 pages in last week's edition of *C&D*, precisely half a side was devoted to Category M in the *Drug Tariff*, the concluding comments of which lead me to assume that those given the task of protecting and advancing pharmacy — Dr Howard Stoate (All-Party Pharmacy Group chairman) and Sue Sharpe (chief executive, PSNC) — are in the dark about the financial implications of Category M to independent contractors.

Dr Stoate and Mrs Sharpe betray a lack of knowledge on how much pharmacy (especially independents) relied on generic reimbursement to remain profitable. Even our local PCT has seen the beneficial cost implications of reductions in simvastatin, ramipril, pravastatin etc and are advising patients to switch from patented brands to these medications.

Where will we recoup these losses? By offering "new services", of which we have no details regarding scope, time or finance and will necessitate locum cover to continue to dispense as usual? By GSK and IVAX removing discount from their products and thereby from pharmacy?

PSNC has failed independent pharmacy in the new contract and I challenge the executive to demonstrate otherwise.

*Michael Gordon
Bolton*

Legal action is a last resort

Camden & Islington LPC considers legal redress over the dispute between PSNC and the LPC only as the ultimate sanction (*C&D*, April 9, p10).

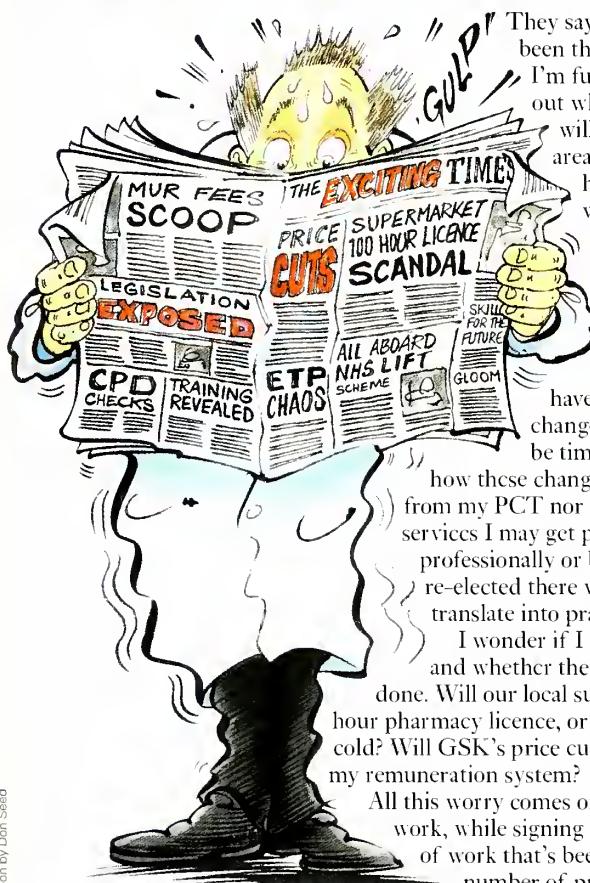
A gentlemanly accord between the two parties should be striven for and a modified financial model, which achieves a more equitable share out of the available funds, is the aim of the LPC.

Such a model is being worked on by the LPC and will be submitted to PSNC for urgent consideration.

*David Kent MRPharmS
LPC secretary*

TOPICAL REFLECTIONS

Coping with the uncertainty of changing times



They say there is no rest for the wicked but have I really been that bad? I have never known such a frantic time. I'm furiously scanning this month's *Drug Tariff* to find out where it leaves me, worrying whether MUR fees will compensate for the installation of a consultation area, and wondering how I will ever find the 60 hours to complete the *Skills for the Future* course, while simultaneously dispensing prescriptions and giving advice. My calculator is about to undergo meltdown and my paperwork pile looks more daunting every day.

While much of my stress is due to worrying rather than actually doing, the uncertainty is deeply unsettling as I try to guess at my future. I have little idea how my working practices are going to change when ETP is installed and whether there will be time to get everything ready. I don't know when or how these changes will happen and, judging by the rumblings from my PCT nor do they. It's anybody's guess which enhanced services I may get paid for next year so I can't prepare myself, either professionally or business wise. If the current Government gets re-elected there will be yet more potential roles but how this will translate into practice is uncertain.

I wonder if I will ever find the time to get to grips with CPD and whether the Society will even be ready to check what I've done. Will our local supermarket be one of those applying for a 100-hour pharmacy licence, or will an NHS LIFT scheme leave me out in the cold? Will GSK's price cuts start a snowball that will make a mockery of my remuneration system?

All this worry comes on top of an ever increasing quantity of 'core' work, while signing the back of prescriptions is about the only piece of work that's been taken away. Patients need an increasing number of prescriptions filling and want to ask my advice on an ever wider range of topics. My staff have increasingly

involved training requirements and business legislation gets more and more complicated. I still have a shop to manage, reps to see, buying to do and meetings to attend.

This is no doubt the most exciting time for pharmacy, but also the most daunting. I only hope that the number of pharmacists suffering nervous breakdowns or simply getting frightened off does not hamper our ability to make the most of the many and varied opportunities coming our way.

Seeing brand leaders in a different light

It seems that Boots is in trouble, launching a number of fundraising initiatives. Its headline-grabbing move, selling Boots Healthcare International (manufacturer of Nurofen, Strepsils and Clearasil), will be of particular interest to independent pharmacists. It has always niggled that the proceeds from these brand leaders goes directly to one of my main competitors and I'm glad that profits from future sales will go elsewhere.

I always try to retain clinical objectivity when selling OTC products, but at the end of the day I'm a businessman and a human being. I can't help a hint of commercial and emotional interest creeping into consultations.

Medicines are always sold on their individual merits but I know who my favourite manufacturers and suppliers are at any given time as well as which products provide the biggest profit margin. I wouldn't be surprised if my sales of Nurofen and Strepsils increased a little, in the same way as sales of Glaxo products have declined recently. I just hope BHI isn't bought by a 'vertically integrated' wholesaler with a pharmacy chain.

These are good products supported by excellent marketing but it must help to have a chain of 1,000 pharmacies pushing the product. It's good news for my patients that I don't manufacture my own OTC brand — it could be my favourite recommendation.

Welsh campaign aims to cut waste

Pembrokeshire Local Health Board is leading a campaign in Wales to educate people about how to use and dispose of medicines properly. It is part of a campaign to reduce the stockpile of medicines that is costing Wales at least £17 million every year, as thousands of medicines which have been dispensed but are unused have to be incinerated.

The *Making Sense of Medicines* campaign, launched on April 11, features a series of television adverts based on a simple traffic light system, advising people to 'stop, think and go' before they collect their prescriptions, as well as asking them to let their GP surgery know if they have stopped taking any medicines.

Delyth Simons, pharmaceutical and prescribing manager at Pembrokeshire LHB, said: "The television advert is being shown on HTV and S4C over 10 days from April 11, with £22,000 of funding. Cardiff LHB has led the campaign and co-ordinated it across the 22 LHBs in Wales."

In addition, a series of 25,000 posters and 50,000 leaflets printed

Don't let your Medicines go to Waste



"Making Sense with Medicine"



in English and Welsh will be distributed to community pharmacies, GPs, libraries and among other health professionals such as dentists and opticians.

"This is part of a strategy to keep the public informed about what we're doing and why we're doing it," added Ms Simons. "We want to make sure that we don't waste more medicines than we have to."

JE

Wyeth rapped over Efexor

The MHRA has upheld a complaint against Wyeth regarding its promotional activity for Efexor (venlafaxine).

The regulatory body said material distributed by Wyeth representatives cast doubt on last December's CSM recommendation to stop using the antidepressant in patients with heart disease or uncontrolled hypertension. In addition to undermining this safety advice, Wyeth's information pack misquoted NICE guidelines on depression to favour venlafaxine, the MHRA said.

MHRA policy group manager Jeremy Mean said: "When it comes to safety issues, the MHRA will not tolerate advertising material – written or spoken word – which has the potential to mislead health professionals or the public. In naming and shaming Wyeth, we hope this message will be clearly understood."

Although the MHRA added that Wyeth has established

procedures "to prevent the public release of such internal documents", Wyeth spokesman Karen Tait said the company disagreed with the MHRA's prescribing restriction, and was appealing against its decision.

Inbrief

Help for locums

Locum pharmacists can get an insight into how the new contract impacts on them at a series of six seminars to be held this summer.

The programme will focus on essential and advanced services and include information on medicines use reviews. The seminars, hosted by Locumlink and sponsored by the NPA, will run in June and September in Birmingham, Bristol, Manchester, Peterborough, Watford and York.

[For more information:](#)

Locumlink

Tel: 0845 1309530

NPA View

Policies, pledges and manifestos

Judy Viitanen, head of public relations at the NPA, explains why it is important for pharmacists to engage now with the general election and parliamentary candidates

The 2005 general election is already shaping up to be a far more exciting, unpredictable and altogether 'sharper' contest than 2001. With pundits suggesting that Labour remains the favourite to win a decisive victory on May 5, rumour has it that ministers are worrying about the size of their likely majority.

Some speak of the majority falling below 100. They point to the loss of about seven seats due to constituency boundary changes in Scotland and the fact that only 30 or so further lost seats are needed to take Tony Blair's majority below 100 for the first time. And political observers believe we will see unprecedented effort put into the grassroots campaign in key marginals rather than a "presidential" national media campaign.

Political rumouring and opinion polls aside, sheer electoral maths makes any outcome other than a Labour majority unlikely, but if there is a serious level of abstention or defection to the Liberal-Democrats by Labour supporters then a hung Parliament is not impossible; while if Labour can motivate its vote to come out in marginal seats, an unprecedented third Labour landslide is still achievable.

The parties have published their manifestos – and are all making important health announcements. Election fever is mounting – and prospective Parliamentary candidates are all actively seeking out local issues, views and concerns. Health is always a hot topic, which means that now is the time to play your part in placing pharmacy on the 'political radar' with your election candidates over the weeks leading up to May 5.

Question them on local health concerns; find out their views on key pharmacy and related healthcare issues. Above all, ensure candidates know about the new contract and its service



benefits for patients, and that they recognise not only pharmacy's future potential, but the challenges, opportunities and issues it faces. Ask candidates to support these in the next Parliament if elected, and in public statements they make on the hustings, in the local media or at public meetings.

The NPA, together with other pharmacy organisations within the All-Party Pharmacy Group, have been working hard to raise the profession's profile with parliamentarians – and we want to push pharmacy up the agenda in this crucial election period. Candidates need to understand your valuable healthcare role in ensuring constituents' wellbeing. Remind candidates how important it is for their party to place pharmacy at the very heart of future health policy.

The part you play locally in 'flying pharmacy's flag' to election candidates can help influence the next government's healthcare agenda. Please get involved.

*The NPA's political lobbying resource, *Lobbying At Local level: A Precis of the Policies, Pledges and Manifestos of the Three Main Political Parties, links to their websites, and political resources, are all available to download from the PR channel in NPAnet – the NPA's member-only intranet. Contact me on 01727 858687, ext 3340, or e-mail press.office@npa.co.uk**

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Look after the profession

Christine Glover, a former president of the Royal Pharmaceutical Society, is stepping down from the Council after 14 years. In her valedictory address to her last full Council meeting last week, she warned against disenfranchising the membership and offered some advice to the incoming Council ...

It has been a great privilege and honour to serve the profession on council for 14 years. Over that time I have found myself in many wonderful, and some not so wonderful, but always interesting, places. All over the world I have met excellent pharmacists doing amazing work and made a lot of very good friends; I have learnt a great deal that has helped me and I have been truly grateful for the opportunity.

It has taken a lot of those years to get pharmacy on the political agenda, and strategic plans developed specifically for pharmacy. This is a long way from where pharmacy was when I first joined Council.

Professionally, pharmacy has never looked more exciting – clinical skills, medicines management, pharmaceutical care, prescribing. This is what pharmacy should be all about. This is what young pharmacists join the Register for. The grind of being tied to the pharmacy bench dispensing ridiculous numbers of prescriptions per hour must go.

The desire to get everything locked inside a competency-based framework should be resisted. Clearly we have to have some, but don't let's throw out professionalism with the bathwater, otherwise patients will suffer and we pharmacists will all be reduced to technicians.

Council's primary task is to take the profession to where it has to be in order to survive and prosper, and this has to be truer today than ever before. This is what leadership is all about.

Being an effective leader will not make you popular; you will earn respect, you will earn trust,

but not popularity. Many of you will have heard me say before that leadership is very closely comparable to parenthood. A good parent supports, sets a good example and, where necessary, disciplines a child. If the parent is successful the child grows into an accomplished, effective citizen with the right value set and a sense of duty and purpose. This is exactly what leaders must do for the profession.

The last decade has seen a steady assault on all the professions – not just the health professions, but lawyers and accountants, to name just a couple of others and there are many more examples wherever you look. Long gone is the time when we could bury our heads in our own patch of sand and pretend that other developments will not affect us.

There is a huge machine slowly but surely grinding our way, and it is essential that you as Council members understand this. It is even more important that you can explain to our members why everything has changed, and will continue to change.

During my time on Council I have talked about communication, communication. When things have gone wrong it's almost always down to poor communication. So when we have to put up the fees and introduce CPD, it's not just to make everyone cross, it is to ensure that we are fit enough to stay around. If we don't make the changes needed the profession of pharmacy will cease to exist. That is what leadership is about, not playing to the gallery.

The fees had to go up, but we



"Life is never going to be the same again after June"

Christine Glover

do need to review how fees are levied and CPD is applied. Disenfranchising pharmacists who have given a lifetime of service to pharmacy cannot be the right way for the profession to behave.

I would like to see 'practising' pharmacists as those who have to deal face to face with patients in an everyday situation, but the idea that someone with a lifetime's experience cannot comment on a medical situation, while someone who knows nothing about medicine is free to give a view, is plainly ridiculous.

We all have a professional duty only to comment within our level of competency and expertise and make it clear where that level is. I hope that the new Council will revise the subject of fees and registration categories very soon.

With that thought in mind, I want to turn to the new Council. When you come to Council you should put the needs of the profession before your own. Sadly that is not always so amongst my fellow Council members. Our corporate responsibility is now laid out in the handbook, which I hope will be my lasting legacy to Council. It has improved our ways of working; it has made our dealings more transparent, and it has evolved around the best Nolan, Trimball *et al* principles.

Even so, whatever is laid down in black and white cannot cover all eventualities, and yes, of course, you can act inappropriately, without integrity, betraying confidences etc, and I expect you can wriggle out of the Code of Conduct we are all bound by.

I know there are members of Council (past and present) who

have not always behaved correctly, and I should like to say to them that not only do you harm yourselves, and lose your colleagues' respect, but also, much more importantly, you harm all 45,000 members of the profession when you do so.

Life is never going to be the same again after June. I very much hope it will be better. I am sure that the larger lay input will make Council more outward looking and less introverted and self-protective.

Some of you members of Council will be here again, and I hope that you will remember that you are here for the profession as a whole and to ensure that the profession acts in the very best interest of the public. You are not here to promote your own self-interest, or just that of the members. That may be a contentious statement, but it needs saying, and I am giving notice that I shall be holding you to it very publicly.

The Society works best when Council works with the staff. They are an amazing group of people, with a wide range of skills, who are doing their utmost to ensure the survival of pharmacy, and I want to express my personal thanks to them for putting up with my lack of technical skills and untidiness, and for their endless patience and support.

I urge those of you who become part of the new Council to work with the staff and to act with the highest integrity for the whole profession, and then I am confident that the profession will be secure for the next 50 years.



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On the hustings

"Pharmacists are highly skilled professionals"

Paul Burstow



Paul Burstow sets out the Liberal Democrats' policy. The Liberal Democrats want to take a different approach to healthcare than simply squabbling over patient choice. We believe that most people's first choice is access to quality healthcare, closer to home. This means recognising that prevention is as important as cure and focusing on primary care.

Pharmacists are highly skilled professionals and it is wrong that the NHS has not always made the most of their skills. We believe that pharmacists have a major role to play in the move towards a primary care-led NHS. We would fund community pharmacists to get more involved with delivering wider health services, improving access for patients to advise and care. This would include involving pharmacists in health promotion by introducing and funding more screening tests in local pharmacies.

The Liberal Democrats will enable individuals to get feedback on their current health status and advice on healthier choices through a health MOT, which would guarantee every person access to appropriate health-screening tests according to their own personal risk factors, such as age, sex, ethnicity and medical history. The results would allow people to receive treatment or lifestyle advice and tackle any emerging

With the general election approaching, we asked the three main political parties for their views on pharmacy

problems sooner rather than later.

We believe that community pharmacists have an essential role in helping people take control of their health, providing easier access to advice, screening, preventive medicine and other services.

Many pharmacists tell us that they often see patients having to make difficult decisions over getting their medicines dispensed because of prescription charges. Charges are unfair because the people who really suffer are those on lower incomes who do not qualify for exemption and cannot afford a pre-payment certificate all in one go. Charges can prevent people from getting the care they need which means their condition could get worse, costing more in the long run.

We agree with the conclusions of the Wanless Report, *Securing the Future Health of the Nation*, which said: "The present structure of exemptions for prescription charges is not logical, nor rooted in the principles of the NHS. Liberal Democrats will commission the first major independent review of prescription charges since 1968 with the aim of extending the range of long-term conditions which qualify for exemption."

The Liberal Democrats were at the forefront of the campaign to defend community pharmacies under threat from Government deregulation plans. According to the Patients' Association, over half of those who use community pharmacies are aged 65 and over.

We argued that rather than extending consumer choice, the elderly and those unable to travel further afield could find themselves without access to a local pharmacy. We stressed that pharmacies should be viewed as part of the health service rather than viewed solely as a competitive retail market.

The Government has said that it rejects the OFT's recommendations to deregulate the market; however their exemptions are a clear move towards deregulation. While welcoming any moves that

genuinely widen consumer choice, the Liberal Democrats fear that the Government's proposals will have a detrimental effect on smaller community pharmacies.

We are also concerned that uncontrolled growth of pharmacy could further exacerbate shortages of pharmacists, affecting local pharmacies and hospitals.

The Government says that it wishes to make better use of pharmacists in delivering healthcare, but its actions tell another story. By proposing a series of exemptions, which will create instability in the community pharmacy sector there is a risk that local pharmacists will be discouraged from investing in new services. In Government, the Liberal Democrats will ensure all patients get fair access to community pharmacy services.

John Reid, health secretary, sets out the Labour perspective. This year marks an historic moment in what is probably the most significant turning point for community pharmacists in the history of NHS pharmacy services as you start implementing the new pharmacy contract.

That an overwhelming 92 per cent of pharmacists voted in favour of the new pharmacy contract is a ringing endorsement of the vision we all share for the role of pharmacy in the future. It offers exciting opportunities to forge new partnerships and working relationships across the NHS, which will benefit patients. The breadth and depth of services you will be able to provide sends the clearest possible message that you are, first and foremost, a front-line service addressing public healthcare needs.

Pharmacists have previously been a huge untapped resource for improving the public's health. The track record of community pharmacists in areas such as stopping smoking, sexual health advice and substance misuse is evidence enough of how integral you are to tackling public health issues.

We would like you to do even more and get involved in aspects

of care such as checking people's blood pressure. This is why we brought in a new contractual framework for community pharmacy on April 1.

The contract will allow community pharmacists to work closer with, and support, other primary care professionals in delivering more patient-centred services. It offers patients better services in four key areas: improving access, helping patients make better use of their medicines, managing long-term conditions and promoting healthier lifestyles.

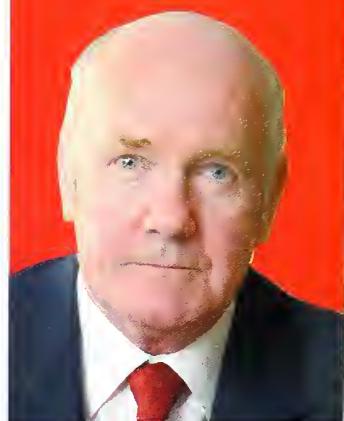
We are currently consulting on independent prescribing for pharmacists, which will allow you to prescribe medicines for a range of common illnesses from acne to tonsillitis, with patients benefiting from quicker access to the medicines and services they need.

By extending pharmacists' prescribing powers, we are giving people more choice about where, and from whom, they can get their prescriptions, both lessening the need for people to visit a doctor or GP and making services more convenient.

Independent prescribing will also make better use of

"You are, first and foremost, a front-line service"

John Reid



pharmacists' considerable skills in pharmacology and therapeutics and enable you to offer a wider range of clinical services, both in the community and hospitals, placing pharmacy at the heart of primary care.

Our agenda for 2005 is ambitious. I know it will mean additional effort and commitment from the pharmacy community, but I strongly believe the new contract will be recognised as a watershed for pharmacy. It will bring significant benefits for patients and a secure and stable basis for pharmacy staff to help the NHS deliver modern services and promote better health for all.

● **Dr Andrew Murrison**
sets out the Conservative Party's plans.

Community pharmacies have remained an untapped resource in our NHS for far too long. There are almost 10,000 pharmacies providing NHS services in England, and each adult will visit them on average 12 times a year – 1.8 million visits every day. A greater proportion of the population visits pharmacies each year than visits their general practitioner. They are therefore in a unique position to offer health advice to patients who choose not to present themselves more formally to the NHS.

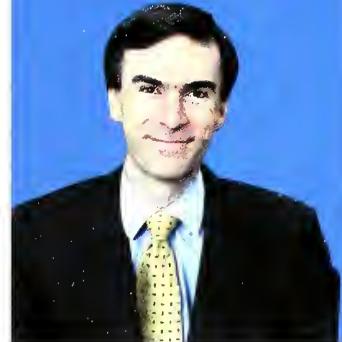
The Government has dragged its feet in reforming community pharmacies. After eight years in office it has this month implemented a new contractual framework for it. In that time conditions such as diabetes, identifiable by pharmacies, have continued to increase. Type 2 diabetes is an important example of where pharmacies can help, given that up to a million people may have the condition without knowing it and the long-term effects of the condition.

The Conservative Party believes that community pharmacies should play a much greater role in dispensing, in giving healthcare advice, in evidence-based screening for common diseases and in providing medicines use reviews for those with long-term conditions. The latter is very important since, as our demographics adopt an older age profile, more and more people will suffer from chronic conditions that can be managed but not cured.

Pharmacists can not only help to take the pressure off other parts of the NHS by offering support to people with chronic conditions, but they may provide a preferred

“The Government has dragged its feet in reforming community pharmacies”

Dr Andrew Murrison



portal of entry to healthcare for many people who would otherwise be reluctant to seek advice or screening. However, pharmacists must be adequately rewarded for additional and enhanced services.

We should explore and expand the role of pharmacists in healthcare. However, on a cautionary note, it is worth pointing out that we have seen unintended consequences from change elsewhere in the NHS. For example, the GP contract, which admirably aimed to further harness the skills of GPs, has meant the demise of Saturday morning surgeries and a move towards a less personal model of healthcare delivery. It would be a pity if, in the course of expanding into other areas, the much-valued role of the high street pharmacist was downgraded.

As community pharmacies acquire the ability to play a greater role in the provision of healthcare, they are under threat from reforms like the deregulation of the sector. The Government's proposals are not as far-reaching as those originally proposed by the Office of Fair Trading thanks in part to lobbying by my Party. However, they threaten the existence of local pharmacies by making it easier to gain licences to open in out-of-town shopping centres. While this may be convenient to some, it is likely to disadvantage those that need pharmacy most – people who are relatively immobile.

We would take a dim view of proposals that are likely to threaten the existence of small pharmacies.



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Our new Child Resistant packs provide additional safety against small fingers - while still working for older ones.

The cartons will carry a child-resistant flash, making them easy to identify.

Nosey or not - you will be starting to see them soon.

ALPHARMA
Making medicine accessible

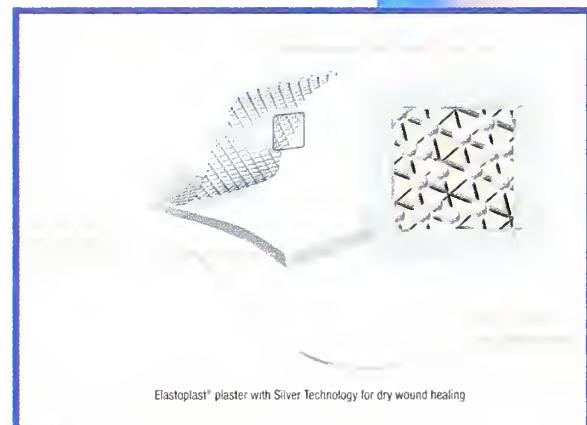
The latest wound care range to be developed for the over the counter market is new Elastoplast® SILVERHEALING™ plasters and dressings, which harness the powerful antiseptic action of silver. So what does silver have to offer today's consumer?

Wound care has come a long way from the days of paraffin gauze, lint and WOV bandages. The healing process is better understood, and a bewildering range of specialised dressings is now available, with many products listed in the *Drug Tariff* for supply in primary care – hydrocolloids, alginates, hydrogels, polyurethane foams, adhesive and non-adhesive, permeable, semi-permeable, film-faced, silver-impregnated, and so it goes on...

Some of these products, such as absorbent film dressings and hydrocolloid plasters, are now available to consumers over the counter for treating minor wounds and blisters. The latest advanced wound care solution to become available OTC is a range of silver-containing plasters and dressings from Elastoplast SILVERHEALING.

Silver has been recognised for its antiseptic properties for centuries, and has been in common use as an antimicrobial since the 1800s, used to treat conditions ranging from venereal disease to acne, and leg ulcers to warts. Its use in the latter part of the last century declined (apart from the use of silver sulphadiazine on burns), perhaps partly because of the advent of topical antibiotics and the fact that, used in the form of silver nitrate solution, it caused argyria (staining the skin black).

However, modern dressings deliver silver in antimicrobial concentrations in a variety of sustained release formats. As an added advantage they do not exhibit staining properties, for reasons that are not yet



Elastoplast® plaster with Silver Technology for dry wound healing



clear. Examples of products listed in the *Drug Tariff* (1) include:

- Acticoat (Smith & Nephew) – two layers of a silver coated, high density polyethylene mesh enclosing a single

layer of non-woven rayon and polyester fabric.

- Actisorb Silver (Johnson & Johnson) – silver impregnated activated charcoal cloth.
- Contreel foam (Coloplast) – polyurethane foam dressing, containing silver.

As a metal silver is relatively inert, but in the presence of wound fluids it readily ionises and becomes highly reactive in binding to proteins and cell membranes (2). Microbiological studies suggest that microbial cells absorb and concentrate silver from very dilute solutions. Once in the cell, silver ions exert their powerful antibacterial effect through binding to and denaturing proteins, either in the cell membrane, or among intracellular proteins and nuclear DNA (3).

The efficacy of silver dressings is closely related to the level of silver released and the duration of action. Silver can be effectively combined with other modern dressings components to give products that help absorb and manage wound exudates, and control the environment of the wound bed to promote healing. It is generally acknowledged that silver has low toxicity – systemic absorption is minimal. However, silver allergy or hypersensitivity may affect a small number of people.

One of the greatest concerns for wound care specialists is the increasing level of antibiotic-resistant

Silver dressings – benefits

- Effective antibacterial action
- Sustained release prolongs activity, helping prevent re-infection
- Anti-fungal activity
- Stimulates dermal regeneration in the wound bed
- Reported to decrease inflammation
- Non-toxic to human tissue
- Non-staining



bacteria being isolated from wounds. Wound infection can delay healing and on occasion can be life threatening (4). The seriousness of this is evident from the high priority given by the NHS to reducing MRSA infection in hospitals. Although some bacteria can develop resistance to silver, recent evidence suggests that most dressings capable of providing sustained silver ion release are effective against MRSA and vancomycin resistant strains (5).

Silver also appears to have a beneficial effect on the wound bed, improving patterns of skin re-growth, wound closure and healing, suggesting that silver ions have a direct effect on the regenerating epidermis (2). There is also evidence to suggest that silver has a local anti-inflammatory effect that can help reduce wound pain.

The use of silver dressings in their modern guise is still a relatively young science, the first sustained release product to come onto the market not yet being 20 years old. However, there is enough good evidence to show that sustained release silver dressings offer effective antibacterial activity and a barrier against re-infection. The introduction of Elastoplast SILVERHEALING allows consumers to benefit from this type of advanced woundcare.

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Promotion

Elastoplast SILVERHEALING – advanced wound healing

SILVERHEALING™ plasters and dressings are the latest advanced wound healing product range from Elastoplast®.

SILVERHEALING plasters and dressings provide a three-in-one advanced wound care solution:

- The powerful antiseptic action of silver provides immediate protection from infection
- The Elastoplast silver wound pad continually releases ions into the wound, helping prevent infection and ensuring long-lasting protection for better, safer healing
- Elastoplast SILVERHEALING plasters and dressings are hypoallergenic and the wound pad is designed not to stick to the wound.

Adapted from silver technology used by healthcare professionals to treat a variety of wounds, the wound pad contains metallic

silver under a polyethylene net. On coming in contact with wound exudate, silver ions are released that destroy bacterial cell membranes, disable their enzymes and inhibit DNA replication.

Silver optimises the natural wound healing process by destroying and minimising the spread of bacteria, and therefore protecting wounds from infection. This scientifically proven treatment method has been adapted by advanced wound care expert Elastoplast to provide advanced wound care treatment in the home.

Benefits of silver

Up to 50 per cent of everyday wounds are contaminated by bacteria and are at risk from infection (Dire et al, 1992). SILVERHEALING plasters not only destroy a broad spectrum of bacteria and fungi, but the use of silver has added advantages over other antiseptics:

- Bacteria are able to develop resistance against most antimicrobial agents, however bacteria show a very low tendency to develop resistance against silver.
- Antiseptics are effective only on their first application, but if bacteria are not destroyed they double every 20 minutes. Controlled release of silver ions into the wound, however, provides a safer long-lasting effect for over 24 hours.



- Unlike many antiseptics that can irritate the skin, silver's allergic potential is low with very few recorded cases of irritation.

It is important to note that additional antiseptic creams or ointments do not need to be used with the SILVERHEALING plasters or dressings as they may decrease their antimicrobial activity.

Elastoplast SILVERHEALING plasters and dressings are available as:

- Fabric Strips 10s (£1.75)
- Aqua Protect 10s (£2.45)
- Sensitive Strips 10s (£1.95)
- Sensitive Adhesive Dressings (£3.69 for 5) for larger wounds.





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omeprazole

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Product Information. Presentation: Each Zanprol 10mg Tablet contains 10 mg of omeprazole. **Uses:** Relief of reflux-like symptoms (eg heartburn). **Dosage:** Adults over 18 years only – 20 mg once daily before a meal. May be reduced to 10 mg daily, returning to 20 mg if symptoms return. Use lowest effective dose. **Contraindications:** Hypersensitivity, pregnancy/lactation. **Precautions:** Refer to doctor if no relief within 2 weeks. Continuous use for 4 or more weeks to control symptoms, aged over 45 with new or recently changed symptoms, unintentional weight loss, anaemia, gastrointestinal bleeding, difficult or painful swallowing, persistent vomiting or vomiting with blood, epigastric mass, previous gastric ulcer or surgery, jaundice, any other significant medical condition (including hepatic or

renal impairment), or pre-endoscopy. **Interactions:** Diazepam, phenytoin, warfarin, ketaconazole, itraconazole, cilostazol, voriconazole, digoxin, tacrolimus, ¹³C-urea breath test. **Side effects:** Skin rash, urticaria, pruritus, photosensitivity, bullous eruption, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, alopecia and increased sweating. Arthritic and myalgic symptoms, bronchospasm, diarrhoea, constipation, abdominal pain, nausea/vomiting, flatulence, dry mouth, stomatitis and candidiasis. Increases in liver enzyme levels, encephalopathy in patients with pre-existing severe liver disease, hepatitis with or without jaundice and hepatic failure. Interstitial nephritis resulting in acute renal failure, gynaecomastia, impotence, headache, paraesthesia.

Taste disturbances, mental confusion, agitation, depression, aggression, blurred vision, blood disorders, hyponatraemia, vertigo, anaphylactic shock and angioedema, dizziness, light-headedness, feeling faint, somnolence, insomnia, peripheral oedema, malaise and fever. **Legal Status:** P. **Retail Selling Price:** 14 Tablets £9.49. **Product Licence Number:** PL 14017/0069. **Licence Holder:** Dexcel-Pharma Ltd, 1 Cottesbrook Park, Heartlands Business Park, Daventry, Northamptonshire, NN11 5YL. **Date of Preparation:** November 2003.

Reference:

1. Bardhan KD, Muller-Lissner S, Bigard MA et al. Br Med J 1999; **318:** 502-507.

Don't forget drug distribution

The plethora of interacting genetic, environmental and other factors that influence absorption and metabolism increasingly interests researchers, pharmacists and clinicians. Sandwiched between absorption and metabolism, distribution doesn't usually attract the same degree of attention. Yet distribution is critical in determining therapeutic outcomes: in some cases the biological processes that control distribution influence the risk of drug-drug interactions, changes in dosing regimens in the elderly and children and whether a centrally acting drug reaches its site of action. This article briefly introduces this relatively neglected, but highly informative, pharmacokinetic parameter.

Body water and compartments

Most drugs reach their sites of action carried in the water in blood as well as extra-cellular and other body fluids. On average, water accounts for between 50 and 70 per cent of body weight, although women have a lower proportion than men. Extra-cellular fluid comprises plasma (about 4.5 per cent of body weight), interstitial fluid (16 per cent) and lymph (1.2 per cent). Intra-cellular fluid makes up another 30 to 40 per cent of body weight. Trans-cellular fluid (2.5 per cent) includes cerebrospinal, intra-ocular, synovial fluids, digestive secretions.¹

In most cases, levels of free drug in interstitial fluid are highly influential in determining the pharmacological effect. Only free drug in interstitial fluid can bind to most cell surface receptors, for example. But the clinical relevance of the various fluid compartments depends on the drug. For example, levels in

synovial fluid of the recombinant monoclonal antibody adalimumab (used to manage rheumatoid arthritis) are between 31 and 96 per cent of those in serum.² Furthermore, several physicochemical characteristics influence distribution between the various compartments, including pH and fat: water partitions.¹ Understanding these variables allows medicinal chemists to devise innovative drugs that reach their sites of action more reliably.

Moreover, some compartments – such as fat, bone and muscle – can act as reservoirs that sometimes store considerable amounts of drug. For instance, up to 70 per cent of a dose of thiopental deposits in fat within three hours of dosing.

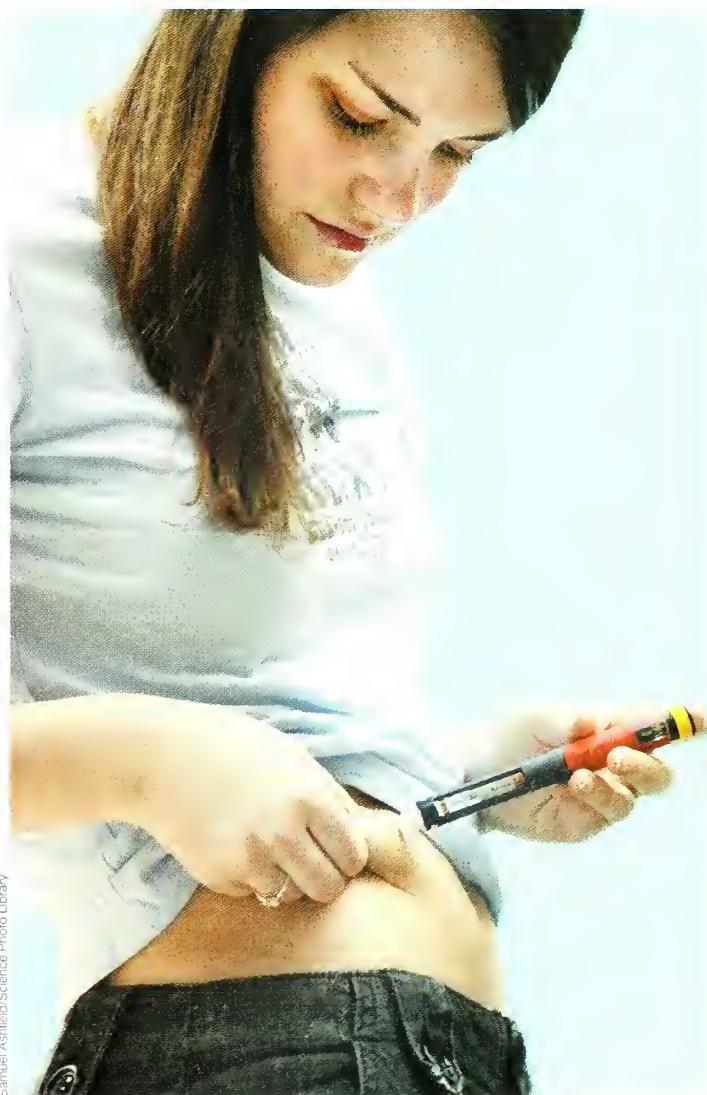
Tetracyclines and bisphosphonates can accumulate in bone. Indeed, bisphosphonates depend on distribution to the bone compartment to exert their effects in osteoporosis, Paget's disease and hypercalcaemia associated with some cancers. However, accumulation in these reservoirs means plasma or serum levels do not always reliably reflect the concentration of the drug in the body.^{1,3}

Furthermore, DDT's high lipid solubility means it accumulates in fatty tissues. Following its once widespread use to control pests, DDT is now in human food chains, especially in meat, fish, milk, cheese and oil, raising public health concerns. DDT's oestrogenic actions, for example, could increase the risk of breast cancer.⁴

Two phases

Distribution through the body's various compartments takes place in two phases, largely determined by the organ's blood supply.

Samuel Ashfield/Science Photo Library



Insulin's onset of action can change when people with diabetes work out

Initially, a drug distributes to organs with rich blood supplies, such as the kidney, liver, heart, lungs and brain. This phase is relatively rapid. Kidneys and adrenal glands receive some 95 per cent of their total distribution within two minutes.

A drug takes longer to reach tissues with a less rich blood

supply, such as fat, muscles, bone and bladder. Reaching 95 per cent of the total distribution in skin and muscles takes between two and four hours whereas drug distribution takes about four hours to reach the same proportion in fat, which has

Continued on page 26

relatively few blood vessels.

Several factors influence blood flow and, therefore, distribution. Exercise can increase cardiac output five or six fold. So people with diabetes can find that insulin's onset of action changes when they work out.⁵ As mentioned later, exercise can produce several other effects that alter distribution. This means pharmacists should be vigilant when patients taking highly protein bound drugs, such as insulin (see later), or a fat-soluble drug, change their exercise habits.

In most cases, drugs need to pass from the blood vessel into the target tissue to exert their action. Drugs can cross capillary membranes either by passive diffusion from a region of high to low concentration, or through hydrostatic pressure. The latter arises from the blood pressure gradient between the tissue's arterial and venous sides and is especially important in 'pushing' water-soluble drugs from the capillary. Furthermore, in the kidneys the gradient arising from the high arterial pressure filters small drugs from the glomerulus into the urine.⁵

More than a fudge

The volume of distribution (V_D) offers a surrogate for the extent to which a drug distributes around the body and penetrates tissues. V_D mathematically describes the volume in which a drug seems to be dissolved. To put it another way, V_D is the amount of fluid needed to dilute the drug to produce the same concentration as in plasma. Clinicians have dismissed V_D as a "fudge factor", especially as the volume can exceed the amount of fluid in the body (which is why pharmacologists usually refer to V_D as the apparent volume of distribution). However, V_D can offer some important insights into a drug's pharmacokinetic profile and, therefore, therapeutic actions.

V_D reflects the way in which drugs distribute around the body. Heparin and insulin are large molecules that do not readily cross capillary walls. As a result their V_D s are small – approximately 0.05 to 0.1 l/kg body weight, which is about the same as the volume of plasma. Gentamicin, carboplatin and other polar drugs are relatively insoluble in lipid, so they do not readily enter cells and have V_D s similar to the extra-cellular volume (0.2 l/kg). Ethanol's V_D is about the same as the total

Table 1: V_D in practice

Barry, a 58-year-old office worker, suffers from congestive heart failure. His doctor prescribes digoxin. Using V_D to estimate the elimination half-life ($t^{1/2}$) helps determine the regimen needed to maintain blood levels within the therapeutic window. The first step is to estimate the V_D at steady state (V_{ss}). In the case of digoxin, V_{ss} is derived from the equation:

$$V_{ss} = 3.12 \text{ CLcr} + 3.84 \text{ litres per kg}$$

where CLcr represents creatinine clearance.

Barry weighs 73kg, so the coefficient of clearance is 100/73. Hence:

$$V_{ss} = 3.12 \times (100/73) + 3.84$$

$$V_{ss} = 3.12 \times 1.37 + 3.84$$

$$V_{ss} = 8.1 \text{ litres per kg}$$

So V_D at steady state is 8.1 litres per kg or 591 litres for Barry.

Most drugs decay by a single-phase exponential function, described in the following:

$$t^{1/2} = \frac{0.693 V_{ss}}{\text{CL}}$$

where CL is the clearance, 6.6 litres per hour for digoxin. So:

$$t^{1/2} = \frac{0.693 \times 591}{6.6}$$

$$t^{1/2} = 62 \text{ hours}$$

A drug accumulates to 90 per cent and 99 per cent of the steady state plasma concentration in 3.3 and 6.6 times its elimination half time respectively. So it would take 8.5 and 17 days for digoxin to reach 90 per cent and 99 per cent of the steady state plasma concentration respectively. Clearly, Barry needs a loading dose defined by the following: **Loading dose = target Cp. V_{ss}/F** , where Cp is plasma concentration and F is bioavailability expressed as a decimal fraction, in the case of digoxin 0.7.

Plasma levels of digoxin between 0.8 and 2.0ng/ml are usually associated with minimal toxicity, so the clinician aims for a dose of 1.5ng/ml.

$$\text{Loading dose} = 1.5 \times 591/0.7 = 1266 \text{ mcg.}$$

So the clinician administers a loading dose of 1mg, divided into several fractions.³

amount of water in the body: 0.55 l/kg. However, some drugs bind outside the plasma compartment or partition into fat. Such drugs – including morphine, propranolol, tricyclic antidepressants and haloperidol – show V_D s larger than the body's total amount of fluid.¹

Several factors influence V_D . For example, the V_D s of numerous drugs vary with age. The V_D s of amitriptyline and cefazidime increase in the elderly. Those of atropine and buprenorphine are higher in children. Ciclosporin's V_D increases in children and declines in the elderly.³ Furthermore, protein binding can alter V_D while contributing to pharmacokinetic changes associated with several diseases and promoting some drug-drug interactions.

V_D is invaluable for calculating clinically relevant pharmacokinetic parameters. Some drugs – amiodarone and digoxin are classic examples – have relatively prolonged elimination half-lives compared with the speed needed to correct the clinical indication (cardiac arrhythmias, for example). Loading doses attain steady state more rapidly, and patients then receive a maintenance dose.¹

Imagine a hole in a bucket. Once you fill the bucket (the loading dose), you replace only the amount that leaks out (the maintenance dose). *Box 1* shows how V_D helps pharmacists calculate the critical parameters. However, toxicity can emerge because some of digoxin's sites of action, responsible for adverse events, rapidly attain equilibrium with plasma. So loading doses are often divided

into several smaller fractions.³

V_D also helps decide the dosing regimen – essentially a function of the half-life ($t^{1/2}$). The simplest (one compartment) model assumes that the body is a single well-mixed unit – the bucket – with a volume equivalent to V_D . Usually, the rate of elimination is directly proportional to the drug concentration and decays exponentially. In such cases, $t^{1/2}$ is directly proportional to V_D .¹

In some cases, two or even three compartment models are needed to describe a drug's behaviour. In these, elimination is bi- or tri-exponential and represents the transfer from central to peripheral compartments, such as the transfer between plasma and tissues and the elimination from plasma. Diazepam, for example, follows a two-compartment model.¹

Finally, drugs such as ethanol, phenytoin and salicylate follow linear kinetics: in other words, the elimination rate is constant and independent of plasma concentration. Such zero-order (also called saturation) kinetics mean these drugs don't reach steady state. The maximum metabolic rate determines elimination and beyond this the drug accumulates. Ethanol, for example, is eliminated at 4mmol/l irrespective of plasma concentration.¹

The protein-binding problem

Numerous drugs (*Table 1*) strongly bind to albumin, globulins, lipoproteins and other proteins. For instance, the globulin alpha₁-acid glycoprotein carries cationic drugs including propranolol and imipramine. Other globulins carry corticosteroids. Albumin transports weakly acidic drugs including salicylates and penicillins as well as several hormones (such as cortisone, aldosterone and thyroxine). Lipoproteins can bind drugs when albumin's binding sites become saturated.⁵

The amount of drug bound by these proteins varies widely. Carboplatin and stavudine are not protein bound, for example and only about 7 per cent of a codeine dose is bound. In contrast, chlorpromazine and diazepam are 95–98 per cent and 99 per cent protein bound respectively.³ The dye Evans Blue binds even more avidly to albumin, allowing

Continued on page 28 ►

Table 2: Examples of drugs that are 90 per cent or more bound to plasma proteins³

At least 90 per cent but no more than 95 per cent bound	More than 95 per cent bound
Amlodipine	Amiodarone
Bromocriptine	Amitriptyline
Cocaine	Atorvastatin
Ciclosporin	Buprenorphine
Donepezil	Calcitriol
Fluoxetine	Chlorpromazine
Haloperidol	Clozapine
Imipramine	Diazepam
Indometacin	Furosemide
Olanzapine	Heparin
Paroxetine	Itraconazole
Prazosin	Ketoconazole
Prednisolone	Naproxen
Selegiline	Nifedipine
Simvastatin	Rosiglitazone
Valproic acid	Warfarin
Verapamil	

researchers to measure accurately plasma volume.¹ Warfarin and other drugs that are more than 90 per cent protein bound show high $V_{D\text{S}}$. Basic drugs also show high $V_{D\text{S}}$, because they bind to tissue as well as plasma proteins.

Clearly, changes in the amount of blood proteins can influence a drug's pharmacokinetics and, therefore, the therapeutic outcomes. And numerous factors can alter levels of blood proteins. For example, severe liver disease and nephrotic syndrome can reduce albumin levels. Cancer, arthritis, myocardial infarction and Crohn's disease induce acute phase reactions that boost levels of alpha₁-acid glycoprotein.³

Furthermore, highly protein-bound agents as well as several endogenous substances (such as bilirubin and fatty acids) may displace drugs bound to serum proteins and vice versa. Such changes in plasma protein binding may prove clinically significant for drugs that are greater than 90 per cent bound to plasma proteins.

As a final example, chronic aerobic exercise can alter $V_{D\text{S}}$ by reducing fat mass and increasing lean body mass, protein levels and plasma volume. Thiopental's $V_{D\text{S}}$ is 76 per cent higher in obese people compared with those who are lean. Moreover exercise, by enhancing the breakdown of adipose tissue, can increase fatty acid levels, which may in turn displace drugs bound to albumin.⁶

Exercising may alter distribution in other ways, including changing the density of membrane transporters.⁶ Some of

these transporters actively move drugs in or out of cells, in many cases against the concentration gradient. L-dopa, gabapentin and baclofen hitch a ride on amino acid transporters, for example.⁵

The extra cellular or intracellular sides of a plasma membrane express drug transporters that mediate influx and efflux respectively. The transporter binds its substrate – such as a drug, toxin or nutrient – and undergoes a conformational change. This releases the substrate on the other side of the membrane. In other words, transporters are "gate-keepers" regulating compounds' movement in and out of cells. Transporters also control the migration of some drugs across the blood brain barrier, which can lead to paradoxical results.

The blood brain barrier

While distribution is, in general, often neglected, some areas at least are attracting considerable interest: ensuring centrally active drugs reach the brain. Paul Ehrlich – the pioneering German researcher who helped formulate the idea of receptors and coined the phrase "magic bullet" – noticed that injecting a dye into an animal stained most tissues. However, the stain did not reach the brain. Ehrlich developed the idea of the blood brain barrier to explain this segregated distribution. We now know that the blood brain barrier consists of an almost continual layer of endothelial cells linked by tight junctions.¹

There are, however, gaps in the

blood brain barrier, which clinicians can exploit. The chemoreceptor trigger zone, for example, is relatively leaky, allowing the zone to help defend us when we ingest noxious substances by triggering vomiting. In general, the dopamine antagonist domperidone does not penetrate the blood brain barrier.

However, it can reach the chemoreceptor trigger zone, where antagonism of dopamine receptors counters nausea and vomiting. Clinically this means domperidone can counter the nausea and vomiting associated with apomorphine in patients suffering from advanced Parkinson's disease. Because domperidone does not cross the blood brain barrier, it does not block dopamine receptors in the basal ganglion, which would antagonise apomorphine's therapeutic benefits.¹

In general, non-ionised, lipid-soluble drugs pass through the blood brain barrier. Ionised drugs or non-ionised water-soluble drugs do not. However, numerous factors – including inflammation – increase the barrier's permeability. Again clinicians exploit this therapeutically. Normally, penicillin penetrates the blood brain barrier poorly. Bacterial meningitis, however, induces an intense inflammation in the cells that comprise the barrier, allowing penicillin to reach the central nervous system. As a result, clinicians can administer penicillin intravenously for bacterial meningitis rather than intrathecally.¹

Furthermore, some polar drugs show higher CNS levels than expected from their physicochemical properties, while several lipid soluble drugs show lower brain permeability than predicted. Drug transporters are responsible for many of these seeming paradoxes, and interactions arising from concurrent drugs' actions on drug transporters can contribute to some potentially serious problems.⁷

For example, some fluoroquinolone antibiotics and anticancer drugs show poor central penetration, despite being highly lipophilic. In this case, a transporter called p-glycoprotein seems to pump the drug across the blood brain barrier and out of the CNS. Quinidine, however, inhibits p-glycoprotein. As a result, concurrent administration of quinidine with loperamide can

lead to centrally-mediated respiratory depression.⁷

To sum up

Distribution is often critical in determining a drug's pharmacokinetic profile and therapeutic outcomes. For example, pharmacists advising GPs or conducting medicine reviews should consider protein binding before making dosing changes.⁵

Numerous factors influence distribution, which pharmacists may need to take into account when evaluating a patient's regimen during a medicines review, assessing the risk of interactions or developing formularies. Far from being a "fudge factor", $V_{D\text{S}}$ is a valuable and insightful parameter that helps pharmacists optimise therapeutic outcomes and implement evidence-based medicine.

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Mark Greener, a former research pharmacologist, is an award-winning freelance medical writer and journalist. He is author of numerous articles, reports and books on health-related issues.

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Pfizer withdraws Bextra

Pfizer voluntarily suspended European sales and marketing of Bextra (valdecoxib) last week, pending completion of the Committee on Safety of Medicines' review of Cox-2 inhibitors.

The company's action was triggered by reports of serious adverse skin reactions, including Stevens-Johnson Syndrome and

toxic epidermal necrolysis, as well as evidence of increased cardiovascular risk. Immediately after the withdrawal, the MHRA issued guidance that patients should see their doctor to arrange alternative treatment.

Pfizer has also withdrawn Bextra in the USA, where it is used more extensively and a higher number of adverse

reactions, including those affecting the skin, have been reported. In the UK, the MHRA estimates that less than 40,000 patients have received valdecoxib over the last year, and said it had received two reports of serious skin blistering through the Yellow Card scheme.

For more information:
www.mhra.gov.uk

Trial shows efficacy of HPV vaccine

A vaccine against human papillomavirus (HPV), which is linked to cervical cancer, has shown promising results.

Over 500 young women were randomised to receive a prophylactic quadrivalent HPV vaccine or placebo three times over six months. The vaccine has been designed to target HPV types 6, 11, 16 and 18 associated with 70 per cent of cervical cancers and 90 per cent of genital warts. Participants were followed up for 36 months for HPV infection or associated conditions.

The incidence of disease or infection associated with the listed HPV strains was 90 per cent lower in the active group than those receiving placebo. Additionally, the vaccine appeared 100 per cent effective against precancerous cervical lesions and genital warts, and no serious adverse effects were reported, say the researchers in a study published online by *The Lancet Oncology*.

The authors say the vaccine could further reduce the incidence of cervical cancer, as well as decrease the associated medical, psychological and economic costs. The vaccine's action against genital warts supports its use in 10-13 year olds, before they become sexually active. Large-scale studies are under way.

For more information:
www.oncology.thelancet.com



Exercise lowers diastolic, not systolic, BP

Exercise lowers diastolic, but not systolic, blood pressure in older adults with hypertension, say US researchers.

Over 50 patients aged 55 to 75 years with untreated mild hypertension received a six-month supervised programme of aerobic and resistance training, and were compared to a control group of non-exercisers. Average drops in systolic and diastolic BPs were 5.3 and 3.7mmHg among exercisers and 4.5 and 1.5mmHg in the control group, rendering the systolic BP decrease statistically insignificant.

The study authors say possible reasons for the "smaller-than-expected" systolic BP change in exercisers include age-related arterial stiffness. But they conclude

that the significant improvement in aerobic and strength fitness, and reduced obesity induced by regular exercise, make it a valuable

way of improving cardiovascular health in older people.

For more information:
Arch Intern Med 2005; 165: 756-762

Scriptlines

Kentera patches

UCB Pharma has launched Kentera, a transdermal oxybutynin patch for the treatment of urge incontinence and increased urinary frequency in patients with unstable bladder.

Measuring 39cm², each 36mg patch releases 3.9mg of oxybutynin over 24 hours. The recommended dose is one patch applied twice weekly to dry, intact skin on the abdomen, hip or buttock, and a new application site should be selected with each new patch. The SPC states that other causes of frequent urination, such as heart failure or renal disease, should be excluded before treatment is initiated.

In clinical trials, the most common side effects reported were application site reactions, dry mouth, constipation, diarrhoea and headache. Contraindicated in patients with urinary retention,

severe GI conditions, myasthenia gravis or narrow-angle glaucoma, Kentera should be used with caution in patients with hepatic or renal impairment.

Price: eight patches £27.20

Pip code: 314-0018

UCB Pharma Ltd

Tel: 01753 534655

Fresubin drinks

Fresenius Kabi has introduced Fresubin Protein Energy Drinks.

Available in vanilla, chocolate and wild strawberry flavours, each 200ml ready-to-drink carton provides 20g protein and 300kcal. Dosage should be calculated by a dietitian or clinician according to individual requirements but, in accordance with ACBS guidelines, should not exceed four cartons a day when prescribed on FP10.

The product information says that the sip feeds are not suitable as a sole source of nutrition, or for

use in infants under one year. The drinks should be used with caution in children up to five years.

Price: 200ml £1.58

Pip code: chocolate 314-2791, vanilla

314-4458, wild strawberry 314-4482

Fresenius Kabi Ltd

Tel: 01925 898000

Clinutren fibre

Nestlé has added a fibre variant to its Clinutren sip feed range.

Clinutren 1.5 Fibre contains 5.7g protein, 18.8g carbohydrate, 5.9g fat and 2.6g fibre per 100ml. The product may be used as a sole source of nutrition in patients over six years, but is unsuitable for children under three. Lactose and gluten-free, the drinks are available in vanilla or plum flavour.

Price: fourx200ml £5.60

Pip code: plum 314-5711,

wild strawberry 314-5729

Nestlé Nutrition

Tel: 020 8686 3333

Hydergine

Novartis Pharmaceuticals has announced the discontinuation of Hydergine (co-dergocrine mesilate) 1.5mg tablets.

The manufacturer said it has decided to stop making the cerebral vasodilator product for commercial reasons. Current Hydergine stocks are expected to run out by the end of June.

For more information:
Novartis Pharmaceuticals UK Ltd
Tel: 01276 692255

Meds Compendium

Community pharmacists can still obtain a free copy of this year's ABPI Medicines Compendium. Containing MHRA-approved information about nearly 2,500 medicines produced by over 120 companies, the hardback can be ordered via the Medicines Compendium link on the www.medicines.org.uk website.



First to the market. Again.



Generic Alendronic Acid is available from TEVA UK Limited. So now the UK's biggest range of quality generic pharmaceuticals just got bigger. Again.



Call Freephone 0800 590 502

and, faithfully

Prescriber Information

Name of the medicinal product: Alendronic acid 70 mg Tablets

Therapeutic indications: Treatment of postmenopausal osteoporosis. Alendronic acid reduces the risk of vertebral and hip fractures.

Dosage: The recommended dosage is one 70 mg tablet once weekly. Alendronic acid must be taken at least 30 minutes before the first food, beverage or medicinal product of the day with plain water only.

Contra-indications: Abnormalities of the oesophagus and other factors which delay oesophageal emptying such as stricture or achalasia. Inability to stand or sit upright for at least 30 minutes. Hypersensitivity to alendronic acid or to any of the excipients. Hypocalcaemia.

Special warnings and precautions for use: Alendronic acid can cause local irritation of the upper gastrointestinal mucosa. Because there is a potential for worsening of the underlying disease, caution should be used when alendronic acid is given to patients with active upper gastrointestinal problems. Oesophageal reactions (sometimes severe and requiring hospitalisation), such as oesophagitis, oesophageal ulcers and oesophageal erosions, rarely followed by oesophageal stricture, have been reported in patients receiving alendronic acid. Physicians should therefore be alert to any signs or symptoms signalling a possible oesophageal reaction and patients should be instructed to discontinue alendronic acid and seek medical attention if they develop symptoms of oesophageal irritation such as dysphagia, pain on swallowing or retrosternal pain, new or worsening heartburn. While no increased risk was observed in extensive clinical trials, there have been rare (post-marketing) reports of gastric and duodenal ulcers, some severe and with complications. Alendronic acid is not recommended for patients with renal impairment

where GFR is less than 35 ml/min. Adequate calcium and vitamin D intake is particularly important in patients receiving glucocorticoids.

Interactions: If taken at the same time, it is likely that food and beverages (including mineral water), calcium supplements, antacids, and some oral medicinal products will interfere with absorption of alendronic acid. Therefore, patients must wait at least 30 minutes after taking alendronic acid before taking any other oral medicinal product.

Undesirable effects: Common ($\geq 1/100, < 1/10$): Abdominal pain, dyspepsia, constipation, diarrhoea, flatulence, oesophageal ulcer, melena, dysphagia, abdominal distension, acid regurgitation, musculoskeletal (bone, muscle or joint) pain and headache. Uncommon ($\geq 1/1,000, < 1/100$): Rash, erythema, nausea, vomiting, gastritis, oesophagitis, oesophageal erosions. Rare ($\geq 1/10,000, < 1/1,000$) Hypersensitivity reactions including urticaria and angioedema, rash with photosensitivity, oesophageal stricture, oesophageal ulceration, upper gastrointestinal PUBs (perforation, ulcers, bleeding), uveitis, scleritis.

Marketing authorisation holder: TEVA UK Limited, Brampton Road, Hampden Park, Eastbourne, BN22 9AG

Marketing Authorisation Numbers: PL 00289/0664

Legal Classification: Prescription Only Medicine

Price: £22.79 for pack size of 4

Date of Preparation: March 2005

For full information please refer to the Summary of Product Characteristics, available from TEVA UK Limited Medical Information Unit.

Isovon isoflavones support for the menopause

A soy isoflavone food supplement for menopausal women is being introduced into pharmacies.

Isovон contains isoflavones which are derived from non-genetically modified soya. Isoflavones are thought to mimic the effect of the female hormone oestrogen in the body.

The one-a-day capsules are designed to help control menopausal symptoms such as hot flushes.

The manufacturers claim the supplement may also reduce the risk of conditions which are common after the menopause including heart disease and osteoporosis.

The product is endorsed by Ingrid Tarrant (TV celebrity Chris Tarrant's wife) whose

statement and image is being used in a £250,000 PR and advertising campaign throughout 2005.

Price: £14.95

Pack size: 30 capsules
Orchid Healthcare
Tel: 0800 3896663



ALLERGY ADVICE Rapid response allergy relief **Benadryl** Active in 15 minutes

HAYFEVER MONITOR

For free pollen alerts text POLLEN to 85080* or log on to www.allergyadvice.co.uk

WEEK
STARTING
16 April



*Initial message is charged at your normal network rate.

To unsubscribe from subsequent free alerts text 'stop' to 85080

© GSK 2005. Further information is available from Pfizer Consumer Healthcare, Walton Oaks, KT20 7NS.

Supernanny sponsorship is child's play for Calpol



Calpol is sponsoring *Supernanny*, Channel 4's prime-time series to help parents deal with unruly children.

The sponsorship is designed to demonstrate that Calpol understands the changing needs of parents and what it's like to have children.

The creative links that open, break and close the programme are in a docu-drama style and centre on children's imagination.

Each episode of *Supernanny* focuses on a different Calpol format. The links have been segmented according to age so,

for example, where a child aged six or over is featured, the creative is branded with Calpol Six Plus Fastmelts.

Christina Matula, senior product manager for Calpol, says:

"Currently, parents associate the brand largely with Calpol Infant Suspension and we want to raise awareness of the other products within the range."

The 13-week TV sponsorship will be supported by eye-catching point of sale material.

For more information:

Pfizer Consumer Healthcare
Tel: 01304 616161

Solpadeine gives pain the chop

GlaxoSmithKline Consumer Health will support Solpadeine with a £0.7 million TV campaign

from April 18 for six weeks.

The TV burst features the brand's martial arts themed

commercial with a powerful pain relief message.

The advertising focuses on Solpadeine Max, which has the maximum levels of OTC painkilling ingredients, but GSK expects the whole range to benefit from the campaign.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637



Turmeric added to herbal range

Bio-Health is adding turmeric to its range of herbal supplements.

Turmeric Rhizome provides 500mg of pure turmeric rhizome in a capsule suitable for vegetarians and vegans.

Herbalists recommend turmeric for relief and protection against inflammatory conditions, relief of digestive complaints and aiding the lowering of blood

cholesterol levels.

Turmeric may also help to protect the body against free radical damage – it has antioxidant properties that are approximately equivalent to levels in vitamin C and vitamin E.

Price: £6.25

Pack size: 60 capsules
Bio-Health Ltd
Tel: 01634 290115

Lamisil®AT blows away the cause of athlete's foot.



Only Lamisil®AT's fungicidal action starts to blow away the fungus that causes athlete's foot from day one

- Only Lamisil®AT is effective after 7 days' treatment
- Only Lamisil®AT 1% cream gives up to 3 months' protection against reinfection
- Only Lamisil®AT has such a dynamite effect on athlete's foot



THE FIRST AND ONLY RANGE TO TREAT IN 7 DAYS

Prescribing information. **LAMISIL AT 1% CREAM.** Presentation: Cream containing terbinafine hydrochloride 1.0% w/w. Indications: For the treatment of athlete's foot and dhobie (jock) itch. Dosage and administration: The cream is applied once or twice daily. The duration of treatment is one week for tinea pedis and one to two weeks for tinea cruris. Not recommended for children under 16. Contraindications: Hypersensitivity to terbinafine or any of the excipients. Precautions: For external use, avoid contact with the eyes. Pregnancy and lactation: Not recommended. Side effects: Redness and irritation at the site of application. Discontinue treatment if an allergic reaction occurs. Legal category: GSL. Recommended Retail Price: £4.99 (7.5g tube). Product licence number: PL 0030/0141* **LAMISIL 1% SPRAY.** Presentation: Solution containing terbinafine hydrochloride 1.0% w/w. Indications: For the treatment of athlete's foot and dhobie (jock) itch. Dosage and administration: The spray is applied once daily for one week. Not recommended for children under 16. Contraindications: Hypersensitivity to terbinafine or any of the excipients. Precautions: For external use, avoid contact with the eyes. Avoid inhalation and do not use on the face. Use with caution on damaged or sensitive skin where alcohol could be irritating. Pregnancy and lactation: Not recommended during pregnancy or lactation. Side effects: Redness and irritation at the site of application. Discontinue treatment if an allergic reaction occurs. Legal category: GSL. Recommended Retail Price: £5.49 (15ml Pump Spray). Product licence number: PL 0030/0147* **LAMISIL AT 1% GEL.** Presentation: Gel containing terbinafine 1.0% w/w. Indications: For the treatment of athlete's foot, dhobie (jock) itch and ringworm. Dosage and administration: The gel is applied once daily for one week. Not recommended for children under 16. Contraindications: Hypersensitivity to terbinafine or any of the excipients. Precautions: For external use, avoid contact with the eyes. Use with caution on damaged or sensitive skin where alcohol could be irritating. Pregnancy and lactation: Not recommended during pregnancy or lactation. Side effects: Redness and irritation at the site of application. Discontinue treatment if an allergic reaction occurs. Legal category: P. Recommended Retail Price: £5.99 (15g tube). Product licence number: PL 0030/0191* *Product licence holder: Novartis Consumer Health, Wimblehurst Road, Horsham RH12 5AB. Date of Preparation: May 2004.

Novartis Consumer Health, Wimblehurst Road, Horsham, Sussex RH12 5AB. Customer Careline 01403 218111 Fax 01403 323919 Email customer.care@ch.novartis.com

Indulgent image for Astral

Dendron is introducing a new look for its Astral moisturiser to promote a more indulgent image

for the brand.

Astral's round blue pot will remain



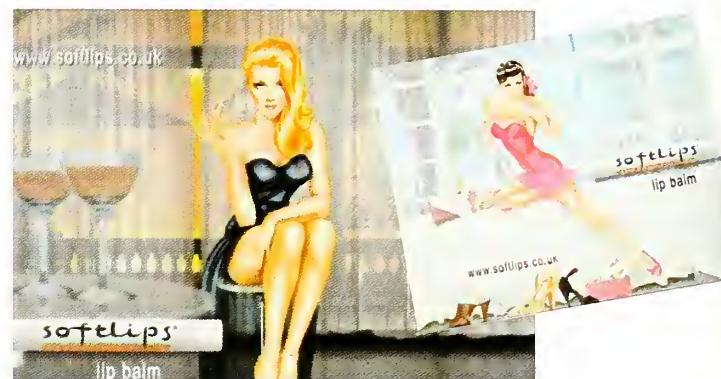
but it has been updated with a new blue label featuring a woman's silhouette to promote the product's use as an all-over moisturiser.

The wording on the pack now conveys the message 'everyday indulgence you deserve'.

Price: £1.49 (50ml), £4.19 (200ml), £7.99 (500ml)

Dendron Ltd

Tel: 01923 229251



Softlips sponsors glamour show

Mentholatum's Softlips lip balm is sponsoring a new series of the popular TV programme *Footballer's Wives*.

The brand will sponsor 10 episodes of the main series on ITV1 and two new spin off shows - *FW TV* and *Footballer's Wives Extra* on ITV2.

Softlips appears in trailers for the series at the start and finish of each show and at the

beginning and end of each advertisement break.

The creatives are inspired by the sexy, glamorous Vargas illustrations from the 1920s to 1950s. Each shows a scantily-clad woman using Softlips and asking 'So ... what are you wearing?'

For more information:
Pharma Consumer Care
Tel: 01202 314824

Ceuta to handle Kodak business

Ceuta Healthcare has been appointed to handle the sales and distribution of Kodak's traditional and digital products to independent pharmacies in the UK.

Alf Webb, business manager for pharmacy at Kodak Digital & Film Imaging Systems says that partnership with Ceuta Healthcare will "enhance Kodak's business in this important sector at a time when the photographic market is

going through a period of rapid change".

Annette D'Abreo, Ceuta Healthcare's deputy managing director, comments: "Kodak is a strong brand in pharmacy with the highest quality products supported by heavyweight consumer advertising. We look forward to further developing the business."

For more information:
Ceuta Healthcare Ltd
Tel: 01202 780558



Aquafresh: All areas except U, CTV, GMTV

Calpol: All areas except U, GMTV

Cura-Heat: All areas except C4, five

Cura-Heat Period Pain: All areas except C4, five

GlucOsamine: M

Lucozade Energy: All areas except U, CTV, GMTV

Lucozade Sport: All areas except U, CTV, GMTV

Nurofen Plus: All areas

Sensodyne: All areas except U, CTV, GMTV

Solpadeine: All areas except U, CTV, GMTV

TENA Lady: All areas except U, CTV, LWT, GMTV

Zocor Heart-Pro: A, M, LWT, C4, Sat

PharmaSite for next week: Southern region - **Glucosamine:** All other regions - **Bazuka - Window, Hayfever Care Range - in-store, Stop Bleed - Dispensary**

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlon, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GT14-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Top speed for Rimmel mascara

Rimmel London is launching a lash-thickening mascara backed by a TV campaign from April 21.

Volume Flash Mascara is designed to give maximum volume to the lashes in one move. It is formulated to thicken lashes without clogging, clumping or flaking.

The mascara is presented in a metallic red pack and comes in two shades - black and brown.

The launch will be backed by a

TV commercial featuring Kate Moss as a sexy biker chick who applies the mascara before setting off on a tour of London astride a mega-cylinder motorbike. The voice-over says, 'Naught to sexy in seconds. New Volume Flash Mascara. The London look.'

Price: £4.99
Pip code: black 312-2405, brown 312-2470
Coty (UK) Ltd
Tel: 020 8971 1300

Carnation steps up support for summer

Carnation Corn Caps and Powerstep Orthotic Insoles will be backed by a £500,000 press advertising campaign starting in May.

Advertising will appear in women's and lifestyle magazines throughout the peak summer footcare season.

A series of roadshows offering free foot health checks in pharmacies is planned for late August and early September.

The Carnation range of 'cosmetic' footcare products will be expanded later this year.

For more information:

Activa Health Care Ltd
Tel: 08450 606707

Coty makes a statement with Exclamation

Coty will launch a new Exclamation fragrance into independent pharmacies and Boots in May.

Exclamation Star has top notes of pink pepper, blackcurrant and green leaves. It has heart notes of jasmine, orange flower and white violet, with a woody base of heliotrope, sandalwood and vanilla.

The fragrance will be available in two sizes of eau de toilette and a body spray.

The eau de toilette is presented in a sculpted glass bottle featuring a gold star and the body spray comes in a gold can.

Price: edt 15ml £6.95, 30ml £9.95; body spray 75ml £2.29
Coty (UK) Ltd
Tel: 020 8971 1300

Problem?

Swallowing difficulties, or Dysphagia, is a widespread problem among people taking tablets. Patients and carers alike open capsules, crush tablets or mix medicine into food and drink to aid administration which can render medicine ineffective. The New Pharmacy Contract encourages pharmacists to ask patients about swallowing difficulties on a more regular basis and to supply an alternative solution. Rosemont focus on liquid solutions and offer treatment in a wide range of therapeutic areas.



Rosemont 

The source of liquid solutions. 

Animal liberation

As pharmacists, where do we stand with the impending new regulations to be applied to the supply of all authorised veterinary medicinal products?

The primary source of legislation now affecting the control and distribution of veterinary medicines is the European Union, so it is important to recognise the gradual move away from legislation which was previously, as that for human medicines, under the *Medicines Act 1968*. Consequently, there will be an increasing number of legislative details which will have fewer parallels with those applicable to human medicines, for better or worse.

Careful scrutiny of the *Medicines, Ethics and Practice Guide (MEP)* and the Veterinary Medicines Directorate (VMD) website, www.vmd.gov.uk, will be helpful to any community pharmacist who may be presented now or in the near future with a veterinary prescription or a request for a treatment of an animal condition.

Much will change as a consequence of the Government's implementation of recommendations from the *Marsh Report* and the Office of Fair Trading (OFT) report. Manufacturers and wholesalers will no longer be able to apply discriminatively disadvantageous terms to pharmacists. Veterinarians will be required to offer prescriptions to their clients and distinguish between their professional fee and the cost of any medicinal products they supply.

In passing, it may be noted that these changes followed consumer protests, particularly from farmers and pet owners, and not by pharmacists. The legislative changes could be a wake up call to pharmacists, helped

Pharmacists have a great opportunity to become involved in a section of medicines supply traditionally overlooked.

Michael Jepson explains

by the recognition that the petcare market is currently worth in excess of £200 million. There is considerable scope for pharmacy investment as, in less than 50 years, pharmacy's share of pet medicine sales has declined from 80 per cent to 10 per cent.

So are pharmacists 'up to speed' with the required knowledge to co-operate with the veterinary profession and all those animal owners who enter community pharmacies every day?

A sensible distinction must be drawn between the commercial farming scenario of food-producing animals and pets or companion animals.

The former is a recognised specialised area of veterinary pharmacy which today can involve 'farm health plans' in order to improve and maintain optimum healthcare of livestock with the appropriate use of prophylactic medication.

At least half of the course for the Diploma in Veterinary Pharmacy (DVetPharm) offered by the RPSGB for over 20 years, targets this long-established area of pharmacy (see *Teachers' pet* on p37-38).

Several specific terms used in the legislation are worth recalling. Veterinarians may only prescribe medicines for 'animals under their care'. This is most important and has some professionally responsible similarities to patient registration with a GP. The term must continue to appear on a vet script.

The standard legally required details to appear on vet scripts for POM and CD preparations are given in the *MEP*, but what is important, though not a strictly legal requirement, is that a vet script presented to a pharmacist should include the species identity of the animal and its weight.

In some cases, the species breed can also be highly important too. Dosage is usually by weight because of the wide variation which can occur. But this could result in more accurate dosage than sometimes applies to humans.

The *Veterinary Formulary* provides authoritative information over a very wide range of issues such as this.

An important legal matter not well detailed in the *MEP Guide* is known as the 'cascade'.

The owner is about to go on a long car journey with Fido

This article can help in the following areas of competence as set out in the RPSGB's CPD manual: **G4, C18, C29, C31.**



No person is allowed to administer any veterinary medicine to an animal unless the product has been granted a marketing authorisation for treatment of the particular condition in the species being treated.

Only if such a product does not exist may a vet legally use a veterinary medicine authorised for another species or for another condition in the same species. This would be described as 'off-label use' and the MA holder's liability ceases to apply. Then and only then, if there is no product to meet those criteria, may an authorised human medicine be used by the vet. Thus if a vet script is presented for a human medicine, the script should be clearly endorsed by the vet. If not the pharmacist must contact the vet and have the script endorsed.

The regulations apply to both food-

producing and non-food-producing animals. The legislative aim is to ensure that medicinal treatment of animals is effective as well as being safe for the animals, for the environment for people involved. In the case of food-producing animals, it also strengthens issues of food safety for the consumer.

While pharmacists are generally aware that they break the law if they supply a P or GSL authorised medicine for human use if intended by a customer for animal use, it can result in an unsatisfactory situation such as this example. It is a Saturday afternoon and you are asked for some travel sickness tablets which it transpires are for a dog. The owner is about to go on a long car journey with Fido and the vet is closed, so referral is hardly an option. There is little the pharmacist can legally do other than to suggest a packet of ginger biscuits,

which may not be taken seriously, but why should pharmacists be put in such a position?

It can be argued that there is an animal welfare issue at stake, too. Disappointingly, so far, such situations do not appear to have been adequately addressed either nationally, including by the professions involved, or by Brussels. If that is not the case, the issues do not seem to have had any publicity. Whatever may happen, if for example, the customer chooses to go to another pharmacy and not disclose the intended use of the medicine, it is surely unacceptable that pharmacists should be put into an illegal situation such as this.

Dr Michael Jepson FRPharmS is joint director of the RPSGB Veterinary Pharmacy Teaching Programme.

Teachers' pet

The Royal Pharmaceutical Society Veterinary Pharmacy Teaching Programme is an ideal way to train in animal medicines.

Course director *Steven Kayne* describes what is involved

The Veterinary Pharmacy Teaching Programme offered by the Royal Pharmaceutical Society since 1981 has recently been relaunched to reflect today's modular approach to postgraduate education.

It comprises four study modules, designed to cover the main areas appropriate to community pharmacy practice. While it is recognised that only a few pharmacists will be in a position to take on this fascinating speciality in depth and provide a comprehensive service to farmers, vets and pet owners, many of us would like to respond to requests for advice and products.

Following changes in the distribution of prescription-only veterinary medicines, dispensing may now become more widespread. With this in mind, two of the modules may be taken as a stand alone unit leading to the award of a Certificate in Companion Animal Healthcare. They are principally studied by distance learning.

Pharmacists wanting a more in-depth qualification may study two further modules, both of which involve short elements of residential study. Successful completion of all four modules leads to the award of the Diploma in Veterinary Pharmacy and the right to use the suffix DVetPharm. This is currently the only diploma currently offered by the Society.

Objectives

- To achieve a standard of postgraduate and vocational education appropriate to the needs of community pharmacists in practice.
- To encourage more community pharmacists to actively participate in veterinary pharmacy.
- To facilitate professional association, interaction and co-operation with



Continued on page 38

veterinarians, farmers and animal owners for the primary benefit of animals and their health and welfare.

To assist many community pharmacists to contribute more proactively and professionally to public health involving animal health matters by the satisfactory completion of the 'Animals and public health' module one.

Programme structure

Modules one and two are studied by following guided reading in the course textbook, completing a workbook with self-assessment exercises and web-based tasks, and by writing two 3,000 word assignments. In addition, attendance at a one-day session is required. This is considered to be an extremely important part of the course as it allows students to interact with colleagues and the course directors and be updated on recent developments in veterinary pharmacy.

Modules three and four are studied over a week's residential period at Harper Adams University College in Newport, Shropshire. Students are required to carry out a minimum of 75 hours' practical experience and produce

business and family commitments. There is a limit of four years for completion of the diploma, allowing you to take just one module per year if you wish.

The four modules are:

Module 1: Companion Animals and Public Health. Deals with the process of pet keeping and public health issues arising from human-animal interaction including zoonoses and food-borne disease.

Module 2: Companion Animal Health

Care. Covers cats, dogs, equines, small mammals and birds, dealing with ecto- and endo-parasite control, nutrition, dermatological conditions and infectious diseases.

Module 3: Veterinary Pharmacy.

Covers the characteristics of veterinary drugs and farming instruments, dairy hygiene and woundcare.

Module 4: Livestock Health & Husbandry.

Primarily concerned with UK livestock, cattle, sheep, pigs and poultry. Reference is also made to deer, goats, ostrich, game birds and other species as relevant.

Cost

The certificate (two modules) costs £500 and the diploma (four modules) £800. If you choose to take the certificate first, then upgrade to the diploma the total cost for the four modules is £900. In addition, the certificate refresher day costs £25 and the residential element of the diploma costs a further £350.

A leaflet on the veterinary teaching programme is available from Lorraine Fearon, Veterinary Pharmacists Group secretary, RPSGB, 1 Lambeth High Street, London SE1 7JN or lorraine.fearon@rpsgb.org

Membership of the

Veterinary Pharmacists Group is free and allows you to keep up to date with developments through the newsletter (on the Society website) and through contact with colleagues working in the speciality (www.rpsgb.org.uk/members). The group runs conferences; the next one, entitled 'Paws for thought' is on July 23-24 at the Whitehouse Hotel, Watling St, Telford, Shropshire.

Veterinary Pharmacy, edited by Steven Kayne and Michael Jepson (course directors), was published by the Pharmaceutical Press in March 2004. It is available online at £39.95 (www.pharmpress.com). Martin Shakespeare has also written a book on zoonoses.

Dr Steven Kayne FRPharmS is joint director of the RPSGB Veterinary Pharmacy Teaching Programme.

Horses for courses

Andrew Cairns explains why it is good business to become involved in the supply of pet medicines

The Competition Commission has made it clear that it sees pharmacists becoming more involved in the supply of medicines for companion animals. This applies in particular to the dispensing of prescriptions from veterinary surgeons because the vet will now be expected to make it known to his customer that the medicine can be supplied through the local pharmacy as well as from himself.

However, this publicity for pharmacy will open the door and alert customers to pharmacy as an option, not only to get prescriptions dispensed, but to purchase other products for their pets from a source of supply that is accustomed to giving responsible professional advice. In addition, the public health aspects of good advice on zoonosis risk and prevention is something that would seem to fit neatly into the expectations raised in the new pharmacy contract.

There are already a number of profitable worming products for cats and dogs that can be sold by pharmacists. In addition to this, the proposed change in the regulations may well be accompanied by the reclassification of high volume flea products into a category that can be sold by pharmacists. Indeed the pet market for ectoparasite products in 2003 was £41 million at manufacturer price (estimated £58.5m OTC), much of which is currently POM but might soon become available to pharmacy. This compares with £47.3m for the OTC sales of laxatives through pharmacy in the same period and £39.3m for anti-diarrhoeals.

The areas for pharmacists to concentrate on are cats, dogs and horses. In time the service can be developed to supply rabbits, hamsters,



You can work at your own pace

a 10,000 word dissertation on an approved topic of their choice. There is a written and oral examination.

Time commitment

For the first two distance learning modules, you are likely to need an average of 80-120 hours (between six and 12 hours a week over three months) plus the refresher day. The full diploma course requires study of modules one and two as above and then a residential week for modules three and four. Completing the practical experience and dissertation might take a further six to eight months. The examinations will require attendance at a venue chosen for maximum convenience to the candidates.

You can work at your own pace (within reason) and structure your work according to



cage birds, homing pigeons and even ornamental fish. Proper advice on medicines, nutrition and hygiene is necessary for all these.

Cats and dogs

We are told that almost half the households in the UK have a cat or a dog and this is an increasing trend. So half of the customers coming through the door are possible buyers of, for example, pet wormers. The average pet owning household spends almost £40 per year on pet medicines so the potential is obvious.

If you decide to have a go then develop a comprehensive range of products to include wormers, flea products, nutritional supplements, grooming products, sundries – leads etc. Gross margins achievable from these products compare very favourably with other OTC pharmacy sections. A one metre run of shelving floor to ceiling is enough to house an acceptable selection of the product groups outlined above. The products that are currently PML (dog wormers for example) and require to be non-self selection will presumably remain the same in their anticipated new category of NFA-VPM after October 2005. A lockable glass fronted cabinet (as for perfumery) is ideal.

Horses

The main equine product area for pharmacists is horse wormers. There are at least 12 different brands of horse wormers currently available and these cover the wormer groups macrocyclic lactones (moxidectin, ivermectin),

benzimidazoles (fenbendazole), and Pyrantel Praziquantel has also been licensed for the treatment of tapeworm in horses. The pharmacist can readily assimilate the knowledge of the species of parasite involved to advise accurately on the correct wormer to be used. It is also becoming evident that anthelmintic resistance of worms in horses requires some form of product rotation so advice for the user is needed.

There can be pressure on price for some of the better known horse wormers so prudent selection of brand and a negotiation with your supplier can pay dividends. Supplies can be obtained from Battles, Trilanco and Westgate, all wholesalers particularly strong in equine product supply.

Pigeons

There are large numbers of homing pigeons in the more densely populated areas of the country. Before birds are raced they should be vaccinated against Paramyovirus disease. Some of your local pigeon fanciers might appreciate having a convenient source of supply of vaccine. The two brands currently available are Colombovac and Nobilis Paramyxo. A good source of information on pigeons and pigeon products is *The British Homing World*, a weekly publication. The main suppliers of the vaccines listed there will be willing to give pharmacists trade terms.

Andrew Cairns is chairman of the RPSGB's Veterinary Pharmacists' Group. 

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OV046

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Focus on health, not illness

The National Association of Women Pharmacists celebrates its centenary this year. At its annual conference in Abergavenny last weekend, delegates heard about Welsh health plans to shift the emphasis away from illness towards keeping people healthy.

Charles Gladwin reports

Plans for health services in Wales are being increasingly structured to make sure they work alongside social care and other agencies.

The Welsh pharmacy plan, *Remedies for Success*, will be updated later this year, following the review after two years of the main Welsh NHS plan, *Improving the health of patients*. Its successor, *Design for living*, was due to be issued this month, but has been delayed due to the general election.

The main thrust is to make sure not only that there is sufficient investment to improve health outcomes, but also to change people's mind set, explained chief pharmaceutical officer to the

Welsh National Assembly, Carwen Wynne-Howells.

As in England, where the pharmaceutical public health strategy was published last week, public health will be a key area for pharmacy in Wales, particularly in community pharmacy, she said.

But she argued that the only way to improve health is to tackle some of the major issues that actually make people ill. "We can never cope with the extent of illness; the only way to deal with this is to make sure you keep people healthy," she said.

The driver now is to promote health rather than treat illness, and with this there is a shift from health promotion to lifestyle



management. Health Challenge Wales is a programme that is intended to stimulate the public into doing something about their health and is something that can be used to help meet the contractual requirements to promote healthy lifestyles, she suggested.

"It is very much about engaging the hearts and minds of people to get involved in health and to get them to think more about protecting their health."

Community pharmacists in Wales have done a lot of lifestyle management providing "hard evidence on how effective pharmacy can be in terms of lifestyle management", such as in smoking cessation or weight management.

"From the point of view of the patient, they find it much more convenient and far less



threatening; patients actually prefer pharmacies as they do not feel they are being 'labelled' or made to feel guilty and as a result are feeling much more confident about it."

With limited resources, there's also a need to focus on need rather than want. While the articulate few can demand healthcare, the less articulate often don't.

Ms Wynne Howells said that across the UK, services are not provided equitably. Twenty years ago, people living in remote rural areas would accept that they were more likely to die than to be given life saving medical care. "That is no longer acceptable. They have a right to the same level of treatment as anyone else. That's quite an amazing challenge, but if we say they have equal rights, they need equity of access and equity of choice. This means we all have to be far more inventive in how we approach things."

Ms Wynne Howells suggested there should be more service user involvement in the decision-making process: engaging the public in the debate about how the resources should be distributed and letting them set the priorities in healthcare can mean the health service works better. This notion will be seen increasingly in pharmacy. "We will ask [the public] what they require from their pharmacy services, not what they want, but what they actually need."

The future's global

Automation – for example dispensing robots – telemedicine and telepharmacy will enable pharmacy to re-engineer services by freeing up staff time and using resources to better effect.

Technological advances may help address the out-of-hours service. Technology can already allow the on-call hospital pharmacist to go online at home and provide after hours advice for the hospital and could lead to provision of a comprehensive out-of-hours service.

At present, of the 60 million prescriptions dispensed annually in Wales, only around 3,000 are marked urgent for dispensing out of hours. "That means that in terms of getting effective services, the return on investment is very

difficult. So for that level of service, why are we not talking about the hospital supplying it?" With a dispensing robot and a secure 'hole in the wall' the on-call pharmacist at home could arrange for the medicine to be supplied at the hospital during the night, proposed Ms Wynne Howells.

Telemedicine, where a doctor in one location can assess a patient in another, can be extended to the pharmacy, she suggested. For example, a patient in a rural area could go to their local pharmacy which could have an IT link to a primary care centre based at the main hospital. Following a 'tele-consultation' with the doctor "what's to stop the pharmacist with their new prescribing rights

issuing the medication to the patient?"

Ms Wynne Howells argued that every healthcare profession is having problems with available skills and personnel. "No GP wants to take a valley practice on", so there will be a need "to think in some radically different ways".

Technology should also allow health practitioners to think globally. If a medicines information service is needed during the night, why not make use of one in the US or Singapore? "The technology is there, the drug market is global, and the drug entities are the same worldwide," said Ms Howells. "But it will need a mind set change to take up some of these opportunities."



All pharmacists should understand the contract

There is a need to demystify the new contract and remove the fear that pharmacists are feeling about it, said Mair Davies, member of the Royal Pharmaceutical Society's Welsh executive.

And this applies to all

pharmacists in the community sector: employee pharmacists and locums need to understand the new pharmacy contract, just as much as

pharmacy contractors, she said.

"If you are a locum, you will be a much more valuable locum if you are accredited to provide the services. But you will also get much more professional satisfaction."

Ms Davies is encouraging pharmacists to make use of the training packs available through the centres for postgraduate pharmacy education. A distance learning pack is already available from CPPE in England, and one for Welsh pharmacists will come out in the next couple of weeks from WCPPE. Funding for training is for all pharmacists, not just contractors.

One of the areas of confusion is what is involved in advanced services, currently comprising medicines use review. "This is not about doing a full medication review; this is about you consulting with the patient and looking at the medication they are on," she said.

Tied in with this is the idea of the need for a consultation area in the pharmacy as MURs should be done on the premises (although there are exemptions for special

needs). "The consultation area is about not using the dispensary, and about making sure the patient cannot be overheard. You will need to look at the consultation areas for sound proofing," she suggested. And as Saturdays tend not to be busy days in terms of prescriptions, this is an ideal day to conduct MURs.

Pharmacists need to be accredited to provide MURs. As locums can work in several primary care organisation areas and even across country borders – some 55 per cent of locums in North Wales come from England – the matter of 'mutual recognition' is being addressed. At present, all the accrediting bodies' courses are recognised in Wales, although pharmacists completing a course need to be aware of any variations between the English and Welsh systems, such as NHS forms. And as PCOs will keep lists of accredited pharmacists in Wales, being on one local health board list means the pharmacist will be able to practice across Wales.

Continued on page 42 ▶



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“Younger pharmacists are not looking for a hierarchical profession but a satisfying occupation”

Carwen Wynne Howells



Above: Mike Burdon, Gillian Hawksworth and Vela Burden before the conference dinner. **Left:** NAWP president Monica Rose and RPSGB president Nicholas Wood at the re-enactment of the first meeting

Taking account of work pattern changes

Pharmacists are changing their work patterns for a variety of reasons and tax may be one of them as the work/life balance becomes more important.

In the hospital service, figures suggest that pharmacists working full time on promotion may look to become a 0.9 or 0.8 full time equivalent and have the same quality of life.

“Where the 40 per cent tax band is kicking in, you get a lot of people opting to move up a grade but work fewer hours,” said Carwen Wynne Howells.

Younger pharmacists are working full time but doing a variety of things in addition,

and this is becoming more and more common, she said. “There’s a very different attitude in that they are not looking for a hierarchical profession, but are looking for a satisfying occupation.”

Older people want to diversify, too. They want to try new areas, not necessarily in pharmacy, and may, too, want a ‘pick and mix’ career, she suggested, as more and more people are starting to look seriously at the work/lifestyle balance.

“This will impact on the way you keep your portfolio and the way that you develop your job,” Ms Howells added.

Public health

Pharmacists’ contribution to public health is wider than getting patients to take their medicines, said Professor Roger Walker of the National Public Health Service for Wales and Cardiff University.

Last week saw the launch of the pharmaceutical public health paper. “The challenge for pharmacists is to move out of the ‘pharmacy box’ with public health,” he said.

Public health is a science and an art, so there is no absolute way of introducing it. “The issue is how we get the message over. As pharmacists, in our contribution to public health we need to think where we want to go and how we will promote the roles. We have to think about the causes of the causes. It’s not that we overeat or drink or smoke, but why we do these things.”

“We need to think where we want to go and how we will promote the roles”

Roger Walker

A duty to consider child protection

Pharmacists may wonder why they need to know about child protection and child abuse, but they have a duty both as a professional and citizen, argued Kate McDonald.

As a PCT facilitator in child protection and a care worker, Ms McDonald said that health professionals may think that it is nothing they need to know about; that they deal with the parents and not the children, or that they do not know what to do.

But pharmacists should ask themselves what would they do if a child is frequently presented with injuries. “What if a parent is frequently buying over the counter medication? What do you do if a mother frequently has black eyes or has injured herself?

What if a mother consults you with a burn which obviously should have been treated?” asked Ms McDonald. These are all reasons to think about your obligation to a duty of care and of protection. “You are already looking at prescriptions and checking they are safe for the children. This is widening it out to see if the children are safe in other ways ... as health professionals you need to ensure that the children who come under your care are safe.”

Child protection procedures are available from social services in England and are made available to all health professionals in Wales. Here the All Wales Child protection procedures state that: “If any person has knowledge,

concerns or suspicions that a child is suffering, has suffered or is likely to be at risk of harm, it is their responsibility to ensure that their concerns are referred to social services or the police.”

The professional *Code of Ethics* also says that pharmacists can disclose information where necessary to prevent serious injury, or damage to the health of a patient, a third party or to public health. And there is nothing within the *Data Protection Act* or the *Human Rights Act* that should prevent the justifiable and lawful exchange of information for the protection of children or prevention of a serious crime.

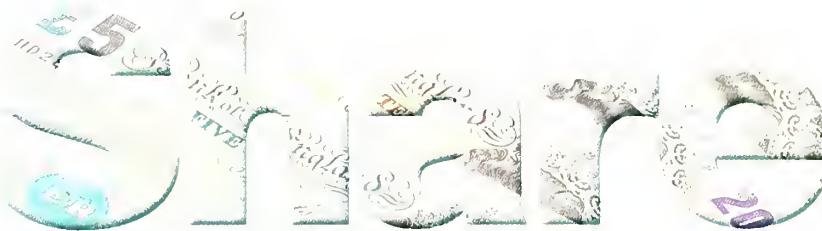
To make the referral, seek advice from the designated, named or lead professional

(usually a doctor or a nurse in the locality) with responsibility for child protection. If needs be, discuss the case as a ‘what if’, “what if a child were to have ... ?” so as not to share all the

information initially. Or phone a social worker or the GP and ask what they think. “Don’t worry that the call will start the ball rolling with the child ending up in care and it will all be your fault,” said Ms McDonald. The case will be noted and investigated cautiously before any information is taken. “And do not think that you have to do any of this on your own. There are child protection officers who can help.”

Training is available and a CD-Rom will go out to pharmacies in Wales in the next six months.

David Kent, secretary of Camden and Islington Local Pharmaceutical Committee, asks for fair shares for all when it comes to allocating funds



in the community

I have held my own counsel long enough. For various reasons, not least of which was the forlorn hope that PSNC was a fair and compassionate organisation and would eventually see the injustice of its treatment of the smaller contractor, I have, until now, declined to openly enter the debate surrounding the new pharmacy contract.

Camden and Islington LPC is, I believe, the worst affected in England. But first I must state my position. I am secretary of Camden and Islington LPC but what follows is written without its authority – it is written as a concerned pharmacist who just happens to be an LPC secretary. It is written with the authority, knowledge and experience of a pharmacist who has practised his profession for over 36 years in all sectors except industry; a pharmacist who has worked in community pharmacies dispensing as few as 200 and as many as 15,000 prescription items per month (ipm); a pharmacist who has been involved with LPCs for over 25 years, formerly as a proprietor member then chairman and latterly (for 10 years) as an LPC secretary.

Why have I felt it necessary to lay out my bona-fides? Camden and Islington LPC has about 36 contractors, out of 109, who presently dispense fewer than 2,000 items per month. Of these, 28 dispense between 1,100 and 1,999ipm. To put this into context, the new contract has a threshold of 2,000ipm for the annual establishment payment of £20,000.

In addition, practice payments of £2,000 annually are paid to those dispensing between 1,100 and 1,600ipm, and payments of £3,000 are available for 1,600 to 2,000ipm. After that the practice payment is 24.2p per item. Exit payments are available for the first full year of the contract for pharmacies with low

dispensing volumes wishing to close. Payments will be reviewed after three years.

I have continually asked a very simple question of PSNC; thus far I have received no answer which I find acceptable: why does PSNC consider it necessary to so gravely disadvantage smaller pharmacies at this time?

I have repeatedly asked where the 2,000ipm bar comes from and on what basis it is arrived at. PSNC blames the Treasury. But on March 15 Camden pharmacist representatives met with health minister Rosie Winterton; she stated firmly that while the Treasury agreed the £1.766 billion funding with PSNC it was PSNC which recommended the distribution

arbitrary level set by PSNC is irrelevant. They do not choose to dispense low numbers; they do not choose to earn relatively small amounts from their professional activities, they accept their position in the greater scheme without complaint. To their credit they soldier on when, in many cases, they could earn more and have an easier life as an employee or locum.

I do not expect many of them to close, but I know that most are disappointed and resigned to the fact that their profession and many of their colleagues will not fight for them.

Pharmacists are not superannuated, and look upon the equity in their business, albeit small, to partially fund their retirement; at a

stroke PSNC has rendered these pharmacies virtually unsaleable or only saleable at a value significantly below what it was under the old contract. Perhaps PSNC would have served us better by addressing the anomaly that we are the only primary healthcare profession that is not superannuated for the proportion of their income

derived from provision of NHS services.

Let us explore this 'new pharmacy contract' a little. We do not actually have a new pharmacy contract; instead, we have a 'new contractual framework'. PSNC points out (on page three of *The New Contract for Community Pharmacy* booklet supplied to contractors) that 'new pharmacy contract' is being used as a shorthand to describe the 'new contractual framework'. That's all.

I wonder how many contractors are aware of the legal differences between a contractual framework and a contract?

The necessary legislation is now in place but the distribution of funds can be changed. I wonder if PSNC will respond to this

Continued on page 44

Why does PSNC consider it necessary to so gravely disadvantage smaller pharmacies at this time?

of funds model to the DoH. And this included the 2,000ipm bar.

The minister further stated that at the mid-term review later this year the Department would be receptive to changes to the distribution model. Will PSNC have the courage and compassion to consider the revised model I will be providing? This will be published for all pharmacists to consider in good time for the mid-term review.

The smaller pharmacies in the UK offer a truly local service – they respond to the needs of patients without having to consult higher authority or company policies. They are a part of their community and their loss will be sorely felt by their patients and others they serve. The fact that the number of prescriptions they dispense is below an



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opportunity to redress a grave injustice.

PSNC makes a lot of the outcome of the contractor vote on the 'new pharmacy contract' in which it claims 92.3 per cent voted in favour. Well perhaps they did, but this was of the 65 per cent total response, so in reality 55.4 per cent voted in favour. Why did so few contractors vote? Could it be that the majority of contracts in the UK are held by large companies which were in favour and whose block vote guaranteed that an independent vote could not possibly win? This does not excuse the lack of participation by smaller pharmacies who should have voted and not allowed PSNC to claim 92.3 per cent in favour.

With 52 per cent of pharmacies being multiples, the outcome of the vote was a *fait accompli* before the papers were ever dispatched.

Turning to PSNC's structure, the penetration of the multiples into that organisation has significantly increased over the years. All PSNC members, some of whom are independents, claim that they look after the interests of all pharmacies including the smallest independents. If this is the case, if they do genuinely fight to protect the interests of the smaller contractors then they are peculiarly ineffective. I do not count AIMp (the Association of Independent Multiple Pharmacies) as being independent. A multiple is a multiple.

The company bias on PSNC is overwhelming and the statements of the multiples that they too have smaller, affected pharmacies, does not wash; no doubt their spreadsheets show that they will gain at the top far in excess of what they lose at the bottom. The single smaller independent pharmacy does not have the luxury of averaging income to reach a satisfactory bottom line. The small independent pharmacy

has little or no effective voice on PSNC.

Before pharmacists above the 2,000ipm bar get too complacent, think about the future. Another fact rarely highlighted is that all prescription levels will be indexed according to national increases in prescription volume. In the last year for which data is available this was 5.7 per cent; thus in eight years the bar will be 2,984ipm and if the growth in prescription numbers, due to repeat dispensing, rises, to say 8 per cent, then in six years the bar will be 2,939 and at 10 per cent growth this is reduced to five years.

In Camden & Islington the rate of prescription numbers increase is around 3 per cent, well below the national figure, and thus the number of pharmacies falling below the bar will increase. I do not believe that Camden and Islington is different from any other LPC area, except in the number of disadvantaged pharmacies. Suddenly the complacency of many of the pharmacies currently above the 2,000ipm bar looks less appropriate.

A lot has been written and said about the possibility of disadvantaged smaller pharmacies being offered local pharmaceutical services contracts by their PCT. I have spoken to both my PCTs on this subject. They confirm that the financial constraints they work under will not allow them to offer LPS contracts to any but the most essential of these pharmacies and then only after the LPS framework is published; contractors may of course find the LPS terms unacceptable.

Interestingly, the minister stated that PCTs had sufficient funds to offer LPS contracts to all affected pharmacies and that the Department had no intention of putting any pharmacy out of business. The PCTs continue to plead poverty!

Inevitably, if taken to a conclusion, we are left with a small number of high volume

prescription mills in each PCT area. No doubt highly efficient and cost effective; but as a patient I want to talk to a pharmacist I know and trust, not the person who is currently on duty.

We must not discount future changes in the management of our profession. It is an open secret that, for some years, the DoH has been talking to consultants from Kaiser Permanente, the biggest healthcare provider in the USA. It can be assumed that if we go down the line of American HMOs then patients may well be directed to pharmacies offering significant discounts to the NHS and have to make co-payments at others. This has been the death knell of independent pharmacy in the USA. Are we next? Am I being over-suspicious in thinking that ETP makes this easier?

We hear a lot about the £1.766bn settlement; I agree it's not too bad a figure but bear in mind the extra work necessary to achieve your fair share and the reduction in profit on purchasing that partially funds it. What is sure is that you will work much harder for your extra money and where does some of this money (we are talking of between £5m and £9m) come from? It comes from the weakest members of your profession.

Never has there been such a blatant case of robbing the poor to fund the rich.

The answer to this problem is relatively simple: at the mid-term review PSNC must put forward a new distribution model which more fairly distributes the available funds. As an example I leave you with a single point to ponder: a reduction in the practice payment from 24.2p per item to 23.87p per item allows each and every item dispensed to attract this fee (with a little left over). Do the larger contractors really begrudge their smaller brethren this 0.33p?

Sue Sharpe, Pharmaceutical Services Negotiating Committee chief executive, replies:

The PSNC response

David Kent has expressed his views about the new contract on many occasions and he is entitled to hold and express them. PSNC believes the new contract and the funding arrangements are fair and provide a strong and secure future for the overwhelming majority of contractors.

Mr Kent is wrong with regard to turnout during the second ballot. In England 73.8 per cent of pharmacies took part in the ballot, of which 92.3 per cent voted in favour and in Wales, 75.4 per cent of pharmacies took part in the ballot, of which 95 per cent voted in favour. It is inaccurate to say that 65 per cent of contractors voted in the ballot. PSNC, with the help of the pharmacy press, widely publicised the ballot together with the publication of PSNC's *New Contract Book* which contained the detail of the proposals.

As a result, the turnout was high, especially if you compare this figure to the turnout for the last two general elections.

In total, including the members of AIMp (regional multiples), 11 of the 31 members of PSNC are representatives of multiples. The remaining 20 are independents. On these figures multiple pharmacies are very substantially under-represented by comparison with the numbers of pharmacies they own.

During contract negotiations PSNC was very mindful of the need to provide protection and opportunities for pharmacies that dispense very low volumes of NHS prescriptions and secure provisions for these pharmacies, including three years' protected payments and limited exit payment options, in addition to the ongoing Essential Small

Pharmacy Scheme. PSNC is also developing, together with the Department of Health and the NHS Confederation, a new type of local contract (local pharmaceutical services) that will be another option for these pharmacies.

What are your views on the remuneration model? Do you agree with David Kent and would you like to see small contractors better remunerated? Or do you think that the distribution model is ok as it is? Should pharmacies in London or other cities have a special case made for them? Should one model fit all? Let us know – send your views to C&D, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1 RW, or fax 01732 367065, or e-mail the editor on cgladwin@cmpinformation.com

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Appointment

Northern Ireland's Department of Health, Social Services and Public Safety has named **Patrick Slevin** as chairman of the Central Services Agency's pharmaceutical committee. A community pharmacist, Mr Slevin has been a member of the Pharmaceutical Contractors' Committee since 1990, and served as PCC chairman from 1997 until 1999.

Trevor Jones, former director-general of the Association of the British Pharmaceutical Industry, has been awarded an honorary fellowship of the British Pharmacological Society. Professor Jones sits on the boards of Allergan and NextPharma and is a visiting professor at King's College London.



Trevor Jones

Seeing red

This year's Red Nose Day saw the second series of Celebrity Fame Academy, schoolchildren the length of the country with big hair ... and C&D staff in their pyjamas. Yes, that's right. The event may have raised £37 million so far, but Sovereign House (home to C&D among others) contributed £395 through a "Wear your pyjamas to work" day. Pictured, from the left, are: special projects administrator Mary Prebble, Price List clerical assistant Maria Locke (loving that tiger print), editorial secretary Jan Powis (red headscarf and glasses part of your nightly attire, Jan?) and production supervisor Katrina Avery.



Red Nose Day also saw the entire staff of Mawdsleys turn up to work in red clothing: £800 was raised



Ball raises £1,000

Pharmacy students from King's College London raised £1,000 for the tsunami appeal at their recent end of year ball. Organised by KCL pharmacy society president and vice-president Sunil Dabasia and Suraj Varia, the event was held at the Royal Garden Hotel in Kensington, and benefited from extensive pharma sponsorship. Over 150 students and

academic staff enjoyed a champagne reception, (courtesy of Alliance UniChem), and a three course dinner, before another 70 people joined for an awards ceremony and raffle, featuring a digital camera supplied by Boots and a £50 book voucher from the NPA among the prizes. The evening finished with a breakdancing demonstration and dancing until 2am.



Pictured are Suraj (left) and Sunil (right) with KCL senior lecturer Dr Ben Forbes, who signed the charity cheque on behalf of the students

Event Photography

Madagascar pharmacy project seeks help

Madagascar, at more than twice the size of Britain, is the fourth largest island in the world but remains one of the poorest countries. For those living in its most deprived areas, a basic health service can make a huge difference.

Azafady, a UK registered charity, works on essential community and environmental projects in some of the most poverty-stricken parts of the island and has a huge focus on healthcare. Last year it built a pharmacy in one of the villages and funded a 'mobile doctor'.

Graeme Jackson, who is taking a three-month break from helping AAH Pharmaceuticals with its PR, plans to work for the charity and is appealing for suitable donations such as sterile dressings.

"I am going with a group of 12 people and, although funding the trip myself, I am also trying to raise a total of £4,000 as a



Children look through the window of a pharmacy built by Azafady volunteers

donation to make sure the charity can continue its good work long into the future.

"I have raised nearly £3,000 but am making a concerted effort to raise the rest by the end of the month. If anyone would like to make a small donation they can contact me at graezej@hotmail.com," he says.

● See www.madagascar.co.uk for more information.

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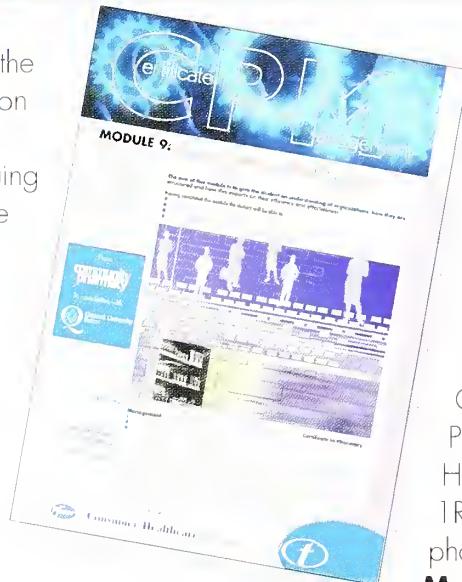
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Reference: 1. Strecher V *et al*. Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-8 August, 2003.